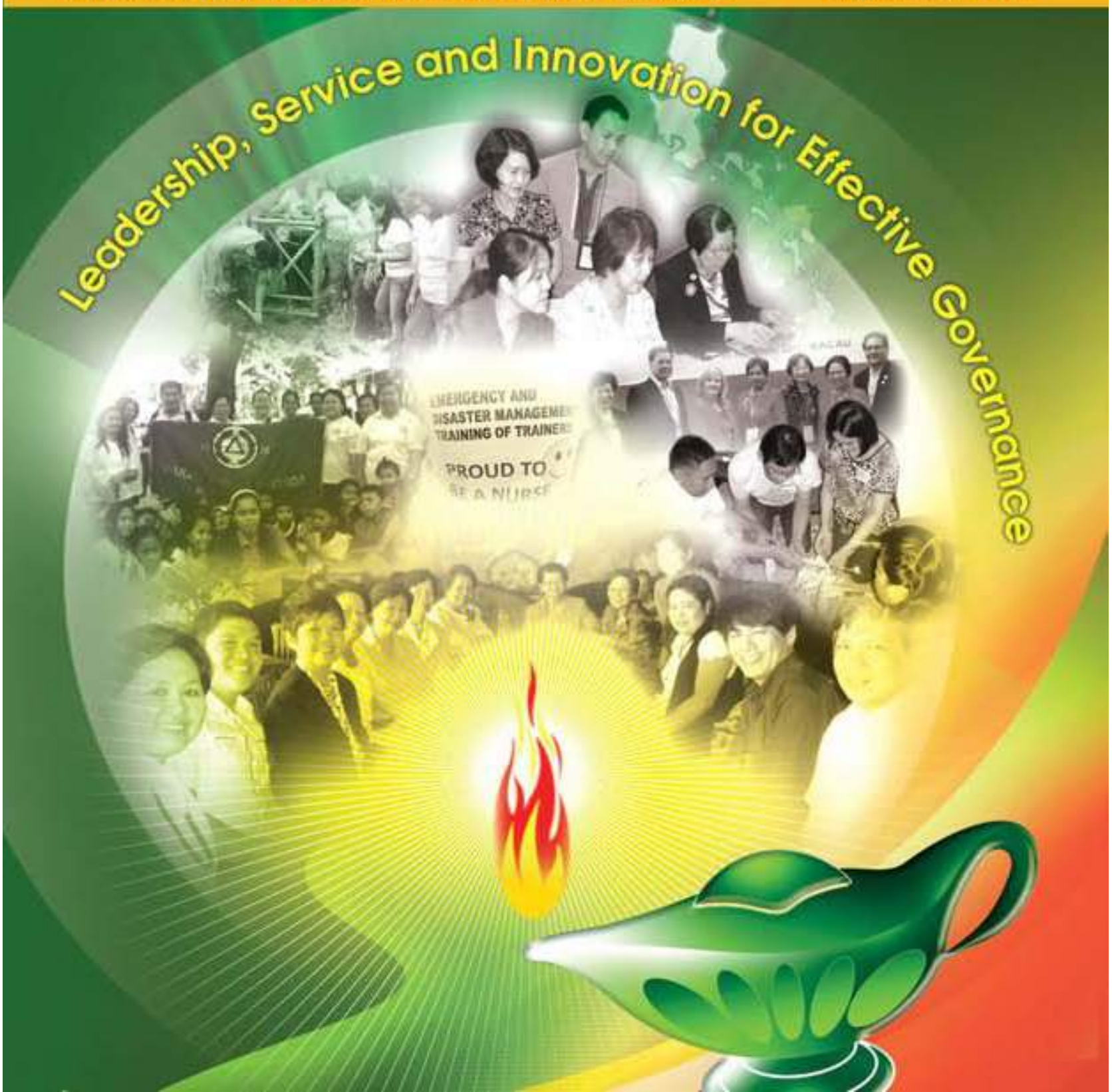
PJN VOL. 81 NO. 2

# PHILIPPINE JOURNAL OF NURSING

ISSN No. 0048-33818

OFFICIAL PUBLICATION OF PHILIPPINE NURSES ASSOCIATION, INC. July-December 2011



# Philippine Nurses Association, Inc.[1]

## VISION

The caring and fortifying light giver committed to providing opportunities for the professional growth and development of world class Filipino nurses, Filipinos and people of the world.

## MISSION

1. Zealously provide strategic directions and programs that enhance the competencies of nurses to be globally competitive.
2. Passionately sustain the quality work life and collegial interactions with and among nurses.
3. Continuously strengthen the internal capacity and capabilities for quality care and services of the nurses.
4. Enthusiastically explore possibilities of collaboration towards unification of nurses.

## PROGRAM THRUSTS

1. Generate programs and activities that would prepare nurses to be globally-competitive.
2. Promote the socio-economic-political welfare of nurses
3. Promote the Positive Practice Environment (PPE) for nurses.
4. Establish national and international networking/ linkages to advance the vison and life purpose of the PNA.
5. Intensify membership campaign.
6. Participate actively in the multi-sectoral plans, projects and programs in support of education and research, nursing practice, and health care delivery to improve the quality of life of the people we serve.
7. Promote the professional image of the nurses and nursing.

[1] *Approved during the 1st BOG Meeting, December 11-13, 2010 at the PNA Board Room.*



# Contents

# Editorial

# Leadership, Service and Innovation for Effective Governance

Leadership, Service, Innovation and Governance are concepts that are as old as human civilization. These are concepts central to any organization. These are concepts that have evolved with the Philippine Nurses Association's 89 years of existence.

Leadership has at length been regarded as the ability to influence a group towards the achievement of certain goals (Robbins & Judge, 2010). This connotes that leadership involves the use of influence. It also implies that to become a change agent, you must be able to affect a follower's behavior and performance. Thus, an effective leader must consider individual, group and organizational goals. These perspectives indicate that leaders are perceived to be agents of change, persons whose acts affect other people more than the other way around. They exhibit attributes of leadership service, ideas, innovation, values, commitment, influence, and tough decision-making. This is where leadership and effective governance converge as these respond to the present and future needs of the organization.

The United Nations Economic and Social Commission for Asia and the Pacific (UN ESCAP) describes governance as "the process of decision-making and the process by which decisions are implemented (or not implemented)." Furthermore, "good governance [has] 8 major characteristics, namely: participatory processes, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive and follows the rule of law. It assures that corruption is minimized, the views of minorities are taken into account and that the voices of the most vulnerable in society are heard in decision-making."

Jazminda Lumang's article on "Leadership, Creativity and Innovation in Democratic Governance: A continuing Challenge to the House of Delegates", posits great challenges to the leaders of the PNA and the House of Delegates (HOD), calling for the development of "a leadership for social transformation grounded on an understanding of the issues and concerns and towards a vision, changing mindsets and attitudes, leading by example, transparent, encouraging participation, and accountable in decision-making."

Reflecting this issue's theme, the study conducted by Dr. Cora Anonuevo, entitled "Transnational Care: Expectations and Realities of Filipino Nurses under the Japan-Philippine Economic Partnership Agreement (JPEPA) Program", explores how the lives of Filipino nurses can be improved within the context of the aforementioned bilateral agreement. Jazminda Lumang argues that Filipino nurses have been known as "the best in the world and it is only fair and reasonable that they are treated well and provided with the work conditions and the protection that they truly deserve." On the other hand, Dr. Al Biag's study aimed to determine the characteristic of servant-leadership of nursing service administrators in government hospitals in Pampanga and Tarlac. The results of the Servant Leadership Inventory (SLI) reveal that a majority of nurse administrators have very low to low servant-first orientation, average to above average receptive responsive caring, above average other centered service, and very low to low instructive transformative relations. This research indicates a reality that continues to confront our nursing profession. Servant leadership should never fade as a core attribute of every nurse. And so, we continue to develop and test theories to improve our practice. As we often say, we nurses care from womb to tomb. Dr. Cecilia Laurente's article explores the theory "Key- Booster System: A Theory in Clinical Nursing for the Terminally Ill". As a mechanism employed by the nurse to boost the self-esteem of the patient, "an important ingredient to enable one to face death peacefully", the nurse turns "helplessness to self-care, powerlessness to personal control, and hopelessness to hope".

The celebration of this year's Annual Convention in Cebu City revolved around the theme, Filipino Nurses driving Access, Quality and Health: Reflections off Gaps in Health Access and Equity. The theme drives toward the point that the concept of

*turn to page 6*

# President's MESSAGE

***Greetings from the PNA National President!***

2011 can be described as a year of expansion for PNA. Expansion has come in several ways. Physically, we have acquired a new building and in the cyberspace we have updated and enhanced our website and opened our official Face Book account. In terms of welfare concerns of nurses, we have reached out to Filipino nurses in Saudi Arabia who had labour problems and with the help of our PNA U.K. chapter, we have disseminated information warning our nurses interested to work in United Kingdom of the unscrupulous practice of recruiting our registered nurses as students with the promise of opportunity to work while studying. Our Filipino nurses in the Republic of Ireland have started the PNA Ireland chapter adding another chapter abroad.

2011 also brought with it natural calamities that put to the test the strength of leadership and commitment to service of PNA not just to its members but also to the people affected by typhoon Sendong in Northern Mindanao. I am proud to say that our nurses, despite their being victims themselves of the disastrous typhoon, braved the floods and worked hard even with limited resources to provide health and psychosocial services to the people of Cagayan de Oro, Iligan and Negros Occidental.

As National President, I have appreciated the crucial role of our regional governors in achieving the thrusts of PNA and in implementing the programs set forth for the year. Being at the helm of our Association is a big challenge but the task is made lighter by the cooperation of every one from the Board of Governors to the chapter officers and the PNA staff. For this, I am indeed grateful.

As I have said to our chapter officers in the general assembly when I assumed office in 2009, the face of the PNA in the field is our Chapter. Having witnessed the energetic participation of our young nurses in the provinces gives me assurance that PNA will continue to climb greater heights and make itself relevant not only to our members but to our country.

In my first message as National President, I have articulated that my watch word for my term of office is Integrity. It is not for me to say if indeed I have lived up to my watch word. I leave that to you my fellow PNA members to say. But I can honestly say that I have tried. I know I am not perfect. But, perfection has not been my goal.

I am confident that now, more than ever, PNA has a strong foundation built on the wisdom of the nursing leaders that have walked the hallways of our Head Office.

Mabuhay ang PNA!

**Teresita R. Irigo-Barcelo,** *PhD, R.N.*

JAZMINDA LUMANG
Executive Director, IBON, Inc

# Leadership, Creativity and Innovation in Democratic Governance: A continuing Challenge to the House of Delegates

On behalf of IBON Foundation, I would like to express my warmest greetings of solidarity to the officers and members of the Philippine Nurses Association's House of Delegates on the occasion of the 89th Founding Anniversary of PNA, 54th Nurses Week Celebration and your 2011 Annual National Convention. In particular, I would like to congratulate the PNA leadership for taking bold steps in shifting course towards more democratic governance in your organization.

I was given a copy of last year's proceedings of the meeting of the House of Delegates and I was happy to see how my presentation this morning is a continuation of your efforts in building democratic governance in the PNA. Having said that, my task this morning is to build on your discussion on this topic and hopefully, to push the envelope further to introduce the concept of people's governance especially in the context of the Philippines.

When we talk of democratic governance, it must be based on people's governance. People's governance is the challenge of building the capacity of the people to make their government accountable and help build democratic governance for real and sustainable development. It is founded on the belief that the foundations of democracy rest on grassroots and mass-based people's organizations asserting their rights (through economic, political and cultural struggles built in social solidarity) and ensuring governance for the people, by the people and for the people.

The Philippine Nurses Association's House of Delegates can play a role in promoting people's governance through leadership, creativity and innovation in democratic governance within the PNA's organization. But before going into that, it is useful for us to understand the context with which our work as leaders of this prestigious organization can respond to.

The world is now in another precarious situation. The unresolved recent global economic crisis which started in 2007 following the sub-prime housing bubble in the US and the contagion that followed in major centers of the developed economies of the world provides an unparalleled challenge not just for world leaders but more particularly to the poorest people of the world.

This provides greater opportunity for development actors in confronting the prevailing neoliberal globalization policies applied to the Philippine economy, and particularly the health sector.

The Philippine health sector continues to be in crisis. The systemic and worsening poverty and inequality in the country have contributed to poor health outcomes, especially for the poorest. The key role of the State is acknowledged yet there is worsening neglect of people's health while increasing attacks on people (including health workers and advocates) are taking place.

Economic backwardness and deep poverty persists with 65 million Filipinos or 70% of the population struggle to survive on P104 (US$2) or less a day while 46 million Filipinos go hungry every day.

Inequality remains persistently severe. In 1985, the top 20% of families cornered 52.1% of total family income leaving the bottom 80% to divide the remaining 47.9% between them. This has barely changed over the last 25 years and in 2009, the top 20% of families still claimed 51.9% of total family income (with the bottom 80% dividing the remaining 48.1%). Also, in 2009, the net worth of just the 25 richest Filipinos of US$21.4 billion (Php1,021 billion at the prevailing exchange rate) was equivalent to the combined annual income of the country's poorest 11.1 million families or some 55.4 million Filipinos (computed with an average family size of five) of Php1,029 billion.

The economic inequalities in the country have grossly affected Philippine health outcomes which continue to be poor and with marked slowdown in improvements over the last 15 years. Infant mortality is at 25 per 1,000 live births in 2008 from 34 in 1993. Under-5 mortality is at 34 per 1,000 live births in 2008 from 54 in 1993 and still trailing other Asian neighbors--Malaysia with only 6, Thailand 14, Singapore 3 per 1,000 live births based on data gathered from the 2010 World Development Index, WB (World Bank) and World Health Statistics and the World Health Organization.

Data from the Department of Health show that the proportion of birth attended by skilled personnel is at 63% in 2005 from 59% in 1990 while maternal mortality is at 162 per 100,000 live births in 2006 from 180 in 1995. TB incidence is at 291 per 100,000 of the population in 2005 as against Malaysia with only 102, Thailand 142 and Indonesia 239.

Comparing data from 1992 and 2008, the percentage of children 0-5 years who are underweight [has gone down from] from 34% in 1992 to 26.2% in 2008. Similarly, the percentage of children below 5 years old who are short is from 36.8% in 1992 to 27.9% in 2008. Meanwhile, underweight incidence in children 6-10 years old is from 34% in 1992 to 26.2% in 2008. Short children aged 6-10 years old are from 26.8% in 1992 to 27.9% in 2008.

In 2003, 26.6% of pregnant women and 11.7% of lactating women are underweight while anemia is prevalent (43.9% in pregnant women and 42.2% in lactating women). Anemia is also widespread in children 6 months to 1 year old (66% prevalence).

The proportion of Filipinos dying without medical attention has marginally dropped from 74% in 1975, improving slightly in 1980 and 1990 with 69% and 59%, respectively, only to get worse in 2000 with 64% and again recovering slightly at 67% in 2002.

Fully-immunized children have seen declining coverage from 69.4% in 1993 to 58.2% in 1997, 61.3% in 2001 and 59.9% in 2003.

Women also have specific reproductive health needs yet family or community medical crisis [are an] additional burden borne by women. The health crisis and conditions are worst for the country's basic sectors (peasants, workers, informal workers).

Indeed, poverty and inequality combined with government neglect lead to grossly inequitable health outcomes. Government neglect can be seen in its budget allocation for health. Current and past administrations have only given less than 3% of its national budget for health. President Aquino's health budget for 2012, for example, is a health privatization budget its health budget does not prioritize the needs of the poorest and most marginalized and in need. It decreases availability and accessibility of health care and [worsens the] quality of health care.

It also does not help that the Aquino Health Agenda prioritizes financial risk protection through Philhealth, greater attention to construction, rehabilitation and support of health facilities and the attainment of MDG 5. Its Health Financing Strategy for 2010-2020 provides the government a limited role in subsidies and distribution of public health funding, thus promoting a greater privatization of health. DOH-retained hospitals are fully corporatized and autonomous; not receiving subsidies while local hospitals will receive minimal subsidies and finally, social insurance is officially transferring responsibility from the society to the individual.

Seeing poverty in the country as simply a “lack of resources” such that the role of private investment in health reforms has been pushed, but instead of achieving significant health outcomes, the Philippine health sector remains chronically ill with millions of Filipinos young and old suffering from hunger, malnutrition, sickness and death.

The last three decades of globalization policies of liberalization, privatization and deregulation have not only seen poor Filipinos, especially young children and pregnant women, continue to fall ill and to have their lives cut short simply because they have no purchasing power and so their wellness has no value in the market. This clear development disconnects where recent economic growth has been

reported as the highest in over three decades and has also been accompanied by rising joblessness and worsening in people's well-being [such that this] must be addressed.

Meanwhile, in spite low key media coverage, the protest actions all over the world against the globalized economy that only benefits the few while marginalizing the majority is escalating. The Philippines, a small democratic nation known for its "people power", is definitely not an exemption and with enough reason.

In spite of pronouncements that the Philippine economy is crisis-proof because of its supposed "strong economic fundamentals", we cannot escape this unrelenting reality. Amid rapid economic growth, our country is still experiencing growing poverty, rising joblessness and severe inequality.

And given the current economic and political situation of the country, the task for genuine social change remains urgent.

Now is the time for professional health workers to take a stand. Poverty is not simply the absence of financial resources. It is also the lack of capability to function effectively in a society. No society can fully develop if its people are unhealthy and unable to contribute productively in nation-building.

Armed with internationally recognized declarations, commitments and conventions on health and development, leaders from the health professions must take action in claiming rights and state obligations for the people's right to health.

There are several international conventions and human rights instruments that we can build on to promote this advocacy. In 1948, the United Nations Declaration on Human Rights Article 25, and in 1976, Article 12 of the International Economic, Social and Cultural Rights recognized the Right to Health as a basic human right. This culminated in the 1978 Alma Ata Declaration.

In spite of these victories, globalization policies in the 80s transformed health from a basic social service or public good to a commodity [whose] whole price is determined by markets, amid privatized health systems and by destroying people's jobs and livelihood. [The] Privatization of health systems was implemented in the US, EU and in third world countries through policy conditions from IFIs (e.g. IMF/WB via structural adjustment programs).

At the same time, the United Nations recognized the Right to Development as a collective right of the people in charting their path to development. But this was later undermined with the intensified free market policies of "globalization" in the 1990s under the pretext of curbing corruption and inefficiencies of governments. In 1993, the World Development Report on Investing in Health aggressively pushed for the privatization of health. By the turn of the new millennium, world leaders pledged to cut, by half, extreme poverty, save millions of lives and billions more to benefit from the global economy via the Millennium Development Goals. Two years later, at the United Nations Financing for Development Conference in Monterrey, donors and governments pledged to increase development assistance to achieve the MDGs. And, in 2005, donor governments and developing countries agreed in Paris to a more effective delivery of aid and management.

Amidst these developments, the challenge for the nursing profession and most especially, the Philippine Nurses Association, remains urgent. Even as many nurses continue to leave the country, the need for more nurses to serve the communities must also be encouraged. The PNA can continue to engage government to develop programs that will promote community nursing and ensure public health services reaching the poorest.

Because of this, the House of Delegates must instill among them the spirit of collective leadership based on democratic governance in the organization whose principles are as follows:

1.) People's human rights and fundamental freedoms are respected, allowing them to live with dignity.
2.) People have a say in decisions that affect their lives.
3.) People can hold decision-makers accountable.
4.) Inclusive and fair rules, institutions and practices govern social interactions.
5.) Women are equal partners with men in private and public spheres of life and decision-making.
6.) People are free from discrimination based on race, ethnicity, class, gender or any other attribute.
7.) The needs of future generations are reflected in current policies.
8.) Economic and social policies are responsive to people's needs and aspirations.

Indeed, the House of Delegates must develop a leadership for social transformation grounded on an understanding of the issues and concerns and towards a vision, changing mindsets and attitudes, leading by example, transparent, encouraging participation, and accountable in decision-making.

Another leadership aspect in democratic governance in an organization involves innovation and creativity. While culture, strategy, technology and other management tools are important, creativity and innovation are what drive organizational success in many sectors and certainly, the House of Delegates can also build on [this]. Existing practice will not suffice and cannot remain top-down [and] bureaucratic or far-removed from the concerns of its members. For organizations to achieve innovation, leaders must establish an environment conducive to renewal and build an organizational culture that encourages creativity. And for creativity to take place, leaders must actively implement a strategy that encourages it. In other words, leadership is the catalyst and source of organizational creativity and innovation.

Organizational creativity also depends on how leaders encourage and manage diversity in the organization as well as develop an effective leadership structure that sustains the innovation process. It also depends on how the leaders inspire their members to bring out their best and their creativity and use that to help stir and transform the organization. No organization can renew or transform itself unless the leaders put the process in motion and sustain it. The House of Delegates must ensure to develop among themselves creative leaders who will manage the innovation process.

Finally, I would like to end by posing some questions for the House of Delegates to ponder as you march ahead in leadership, innovation and creativity based on people's governance: Do you have a vision based on democratic governance? Are your advocacies built on community and people's organization linkages? Do you encourage an enabling environment for constructive engagement? Are you open to new advocacy tools?

I hope that at the end of your annual convention, these questions are taken into consideration and hopefully, steps will be taken more strongly for the greater good and for PNA to be an organization for social transformation.

Mabuhay po kayo!

*Editorial... from page 1*

leadership, service, innovation and effective governance should be contextualized. Being so, the PNA as the broadest professional organization of nurses must be able to realize and operationalize democratic governance. We must be able to contribute to organizing people for their "rights through economic, political and cultural struggles built in social solidarity and ensuring governance for the people, by the people and for the people". An epitome of such a nurse leader is a Nurse-Unionist,a current member of the Board of Regents of the University of the Philippines, the first nurse ever to be given such an honor and privilege, Mr. Jossel Ebesate of the UP-PGH. His story, captured by Eleanor Nolasco, is truly inspiring.

For our young and dynamic nurses being honed and challenged by dedicated mentors, we pay tribute to Dean Evangeline Maceda Dumlao, a genuine servant leader, whose life has touched countless nurses and health professionals. Dr. Carmelita Divinagracia and Dr.Cecilia Laurente, renowned nurse leaders, once mentees, write her story of passion, humility and integrity.

We lose…we gain. Dan Erwin Bagaporo, emerging student nurse leader of the UST College of Nursing, wrote an essay, "Pride in Profession," which won the 2011 Goi Peace Foundation - UNESCO International Essay Contest for Young People. Tita Rillorta, a community health nurse in Isabela, who teaches at the College of Nursing of Our Lady of The Pillar Cauayan, shares her passion and struggles with alternative medicine. This is her advocacy for a treatment modality that is "financially and culturally sensitive and accessible to the basic masses".

This 2012, the challenges are many and formidable. But with the collective leadership, dedicated service, commitment and democratic governance of the elected officers of the organization, we should not go wrong. They shall inspire us, their constituents, to "dream more, learn more, do more and become more" in the service of the Filipino people.

Erlinda Castro-Palaganas, RN, PhD

References

What is good governance? UN-ESCAP. Retrieved January 16, 2012. http://www.unescap.org/pdd/prs/ProjectActivities/Ongoing/gg/governance.asp

Robbins, S.P. & Judge, T. 2010. (14th Edition). Organizational Behavior. Prentice Hall, USA


CORA A. ANONUEVO, PhD, RN
• *Professor, College of Nursing*
*University of the Philippines Manila*
• *Member: Sigma Theta Tau International Honor Society of Nursing Iota Chapter, California, USA*

# Transnational Care: Expectations and Realities of Filipino Nurses under the Japan-Philippine Economic Partnership Agreement (JPEPA) Program

On 29 September 2011, a daily newspaper bannered this caption: *Japan okays review for Pinoy nurses.* The news article partly read: "The Japanese government has agreed to review the process of accepting Filipino nurses in its hospitals under the Japan-Philippines Economic Partnership Agreement (JPEPA). This was the result of the bilateral meetings between President Benigno Aquino, Jr and Prime Minister Yoshihito Noda regarding people exchanges, including the Philippines' request to look into the reason why only a few nurses passed the Japanese National Examination since the implementation of JPEPA in 2008" (Philippine Daily Inquirer, September 29, 2011).

## Background of the JPEPA

It was in December 2008 that the JPEPA was ratified by the Philippine Senate. It came two years after the Japanese Diet or Congress approved the treaty in December 2006.

Annex 8, referred to in Chapter 9 of the JPEPA on the Specific Commitments for the Movement of Natural Persons, covers the recruitment of nurses and careworkers through government-to-government arrangement. It provides for the entry and temporary stay, under certain conditions, of "nurses or certified careworkers or related activities, on the basis of admission to public or private training facilities" in Japan. Minimum requirements set for this purpose under the national examination scheme of JPEPA are as follows: (1) nurse (*kangoshi*) should have at least three years of work experience as a registered nurse; (2) careworker (*kaigofukushishi*) should be a graduate of a four-year college degree and certified as a careworker by TESDA or a graduate of a Nursing course. Filipino nurses will be allowed to stay for three (3) years in Japan but must pass the national examination within this period of stay. The careworkers will be allowed to stay for four years as they are required to have three-year work experience in Japan prior to taking the examination on the fourth year (Specific Commitments for the Movement of Natural Persons, 2011).

Both the nurse and careworker candidates and trainees (either of these terms is used to refer to foreign health workers under the JPEPA) undergo the Japanese language training consisting of 675 hours and 141 hours, respectively, for socio-cultural adaptation training.

The Philippines Overseas Employment Administration (POEA) and the Japanese Ministry of Health, Labour and Welfare through the Japan International Corporation of Welfare Services (JICWELS) coordinate the JPEPA program. Within two years, 400 nurse candidates and 600 certified careworkers or caregivers (CG) are expected to be deployed to Japan.

According to the POEA, on its first year of implementation in 2009, a total of 266 Filipino (88 nurse candidates and 178 CG candidates) were finally deployed in the different health care facilities in Japan. On its second year, the batch consisted of 46 nurses (44 females, 2 males) and 73 CG (all females).

### Purpose of the Study

This study aimed to find out, from the nurse candidates, what they know about the JPEPA, their motivation to participate in the program, and what they see as prospects while "working" in Japan. It also attempted to present their situation and realities within the framework of the commitments spelled out in Annex 8, Chapter 9 of the Agreement.

### Method

Participants of the study belonged to the second batch of nurses who attended the pre-departure orientation (PDO) seminar held at the POEA in May 2010. Twenty (20) out of 46 nurses in attendance willingly participated in the focused group discussions (FGDs) which were conducted immediately after the PDO. The activity was designed to collect data in relation to a bigger study on Transnational Careworkers under the JPEPA. The FGDs were conducted by two Filipino nurse faculty from the University of the Philippines Manila, including this author, and a Japanese social scientist researcher who served as an observer.

The participants were all females who were divided into two groups, each group consisting of 10 members. Group A members had less than four (4) years of work experience, while Group B members had four (4) or more years of work experience. Work experience classification was in line with the basic requirement set by the JPEPA. The FGD was guided by ten (10) questions and lasted for one-and-a-half hours.
Ten months after the FGDs, in March 2011, two follow-up FGDs were conducted with nine (9) nurse candidates deployed in two hospitals in Japan. This activity was conducted with the permission of their employers.

## FINDINGS

This section presents the Filipino nurse candidates' expectations and realities regarding their participation in the JPEPA program.

### Before Deployment: The Nurse Candidates' Expectations

#### Main reasons for choosing to work in Japan

Both groups A and B shared the general perception that the technology is Japan is more advanced, if not better, and that this is true for the health care system. Group A pointed out that the JPEPA would offer good opportunities without the need to pay for a placement fee. Some of them stated that they are attracted to the Japanese culture especially 'manga' (Japanese word for comics or cartoons). Group B cited Japan's close proximity to the Philippines, both being in Asia; hence, culture shock may be easier to overcome. Some mentioned that their families could easily visit them in Japan. Others said that they opted to work abroad because they are not well compensated for in the Philippines. Accordingly, working overseas would provide them with enough money for their family's food, education and housing, notwithstanding professional growth.

#### How they learned about the JPEPA

Most members in both groups said that they learned about the JPEPA through the POEA website, or through their friends and personal contacts in the first batch of applicants. A few in Group A said they caught it on the TV news. A participant of Group B replied that she came to know about JPEPA through her sister who was working at the POEA.

#### What they know about the JPEPA Program

A majority in both groups were aware that JPEPA is an economic arrangement between Japan and the Philippines. As an agreement between the two countries, they further noted that the Philippines will have a commitment to send nurses and caregivers to Japan. Some of the Group A participants mentioned that this program will help the Philippine government obtain jobs for its citizens. While Group B participants supposed that with this partnership, Japan will aid in the development of public works and highways in the Philippines. In exchange, however, a few expressed alarm that waste materials from Japan may be dumped in the Philippines.

#### What they foresaw as their rights and responsibilities under JPEPA

Only the participants of Group B responded to the question on one's rights within the JPEPA framework. They mentioned the provision of equal rights, salary and benefits such as insurance and free accommodation. Some believed that they should have continuing education and training to enhance their professional competence and that this should be funded by their employers.

As to their perception about their responsibilities, Group A expressed that they should be "model Filipinos." Most in Group B said that they have to prove that Filipino nurses are highly competent. But they were aware that they had to work as nursing assistants initially until they pass the Japanese Nursing Licensure Examination. They added that they had to learn the Japanese language and culture.

#### Preparing for work in Japan

Almost all participants in Group A and Group B verbalized that they did self-study and read about Japan, especially with regard to language and culture, and the city or province of their destination. A few in Group A said that they informed their children and families about their departure but not honestly about how long they will be away, especially to their children.

As most participants in Group B were experienced overseas workers, they said that it would help them adjust to look for friends and contacts in Japan just as they did in previous years while abroad. They also had personal talks with their children and families but for married participants, they expressed that this process was a struggle because of separation anxiety.

### Reactions of their Families

Most of the Group A participants felt that their decision to work in Japan was supported by their families. However, some said that their families were worried about their welfare in a foreign country, as well as the emotional adjustment of their children. Still, according to most participants, their families remain hopeful that "*life will go on.*" A few mentioned that they have relatives in Japan so they were glad for the opportunity to get in touch with them. Group B participants believed that the financial rewards outweigh the separation from the family. Their families were optimistic that if they pass the examination, the former could join them and live with them in Japan.

### Three main concerns regarding travel and work in Japan

Participants in both groups expressed the following concerns: the need to adapt to the Japanese language and culture; the possibility of communication barriers; and the difficulty of passing the licensure examination.

### How they see themselves after three years and beyond

Group A participants expressed a desire to continue working in Japan for as long as there are willing employers. They see themselves as licensed nurses in Japan and with such a case, they can bring their families there to visit or to reside with them. Some hope to move up in terms of their career as nurse supervisors or head nurses. In Group B, almost all said that they intend to stay in Japan and return only to the Philippines upon retirement.

### Ten Months After: Their Realities

*Profile of the nine participants.* Four out of 9 in this group interview were FGD participants in Manila. Five are married but one is separated; the other 4 are single. The youngest is 28, while the oldest is 39 years old. Except for one, all had worked for at least 4 years in the Philippines or abroad as staff nurses.

Eight are assigned in a tertiary geriatric care hospital and one in a rehabilitation hospital. Both facilities cater to elderly patients in need of long-term care.

All the candidates who were interviewed took the National Examination, which consisted of 240 items in Japanese language, in February 2011. They had a short preparation period, two months after their six-month basic Japanese language course.

### Life at the Workplace

The nurse candidates described their new work as "not challenging" at all. They expressed that they do not perform "real nursing functions" as they are confined to doing three tasks: feeding, bathing and assisting in the toilet needs of their elderly patients from 8:30 am to 5:00 pm. Other activities they do include distributing tea to the patients, dusting, wheelchair repair, changing diapers, bedmaking, mopping, and toilet cleaning which they refer to as menial jobs. They mentioned that there are no male health care utility workers to carry or lift heavy patients and equipment so they depend on themselves to do the lifting. One of their batchmates, in fact, went back to the Philippines three months after deployment in a health care facility because she encountered difficulty in the work, especially with lifting huge patients.

Career-wise, they were concerned that, after three years, they would need to catch up with their nursing skills. *"Nakapanghihinayang* [Regrettable],*"* lamented one nurse candidate as she compared her present job to her previous work in the Philippines, which she described as challenging. "Toxic…. But I liked my work there because it helped me grow professionally.*"* Another nurse candidate said "'*di gumagana ang utak namin dito* [our brains do not function here]." "*Nakakapurol* [It dulls the mind]," another exclaimed to depict the effect of rutinary work. One uttered, "*nakaka-bore dahil routine ang ginagawa* [It's boring because all we do is routine work]." Another one said that she missed the sort of job she used to have in Qatar as an ER (emergency room) nurse.

### Salary and Benefits

Despite these complaints, all said that they were satisfied with their salary. For instance, one confided that her monthly salary amounts to 160,000 Japanese yen, which is roughly equivalent to 80,000 Philippine pesos. She has a net pay of 120,000 yen or 60,000 pesos after deducting 40,000 yen for tax, insurance and living expenses. From the 60,000 pesos, she sends an average of 40,000 pesos per month to her family in the Philippines, and saves the remaining amount personally.

The candidates described their accommodations as modest, comfortable and complete with household appliances. Two persons share a room that has a study corner. They also have a stock room for their supplies and other personal things. In addition, the candidates said that they are provided with free train tickets, courtesy of their employer. This allows them to go to places for shopping and recreation. However, they pointed out that salaries and the provision of benefits and perks differed according to institution and employer. They reported to experiencing varying monthly salaries ranging from 120,000 to 230,000 yen. Some candidates are not given free accommodations.

### Continuing Japanese Language Education

On the other hand, they are generally happy that they are in Japan and they consider their present situation only as temporary. All the nurse candidates, except for one who is assigned in a rehabilitation hospital, report for duty two times a week, while attending to other work daily for eight hours. For the rest of the week (three days, from 8 am to 5 pm), time is allocated to the continuing language courses and self-study modules. They are off-duty on Saturdays and Sundays, during which they devote their time to house cleaning, shopping and group study. They expressed their appreciation of this arrangement as it has helped them prepare for the examination. They added that they need to be very familiar with the medical terms in *Nihongo* as well as practice writing in *kanji* which is considered the most difficult Japanese writing style. This kind of arrangement is not the same in all health care facilities. They mentioned that some of their batchmates study the language full-time while others do self-study most of the time. This is the case of the nurse candidate assigned to a Rehabilitation Hospital who only has two hours of language study from 4 pm to 6 pm, five times a week.

### Language barrier

The candidates shared their discomfort about the difficulty of the Japanese language. Exclaimed one candidate, "*Kinakabahan kasi di masyadong maintindihan ang salita nila dahil may dialect intonation,* [(I'm) Anxious because I don't understand much of what they say because of the dialect intonation]." She added, "*Yung tinuro kasi sa amin, Tokyo style,*" [What was taught to us was the Tokyo style (of speaking)]. Another one expressed that a nursing job is tough, especially when communicating with patients. She said they have to understand the local dialect spoken by their patients.

However, most of them remarked that language did not pose any problems when it came to taking care of elderly patients. They described the patients as kind, cooperative and generous. What the candidates lack in verbal communication or conversation, they compensate through non-verbal communication such as gentle and genuine touch, pleasing facial expressions and appropriate hand signals.

### Relationship with Japanese employers and co-workers

All the candidates interviewed expressed their appreciation for the support and assistance of their employers, supervisors and co-workers. Most of the candidates shared that their superiors were very helpful and accommodating to their needs and requests. One mentioned that they were given household appliances and winter clothes. Meanwhile, the Japanese nurses expected them to be open and honest, *"gusto nila magsabi kami sa kanila ng lahat,* [They want us to tell them everything that we need]," one uttered. Another nurse conveyed that she and her group mates were just fortunate to have an employer who had a warm attitude toward them. They knew that some of their batchmates were not in a similar situation, having very strict and indifferent Japanese superiors.

### Their Recommendations to Issues and Concerns

Most of them suggested that in order to learn the Japanese language quickly, the basics of the course should be conducted in the Philippines before they are sent out to their respective employers in Japan. Then, the continuing language education can be conducted in Japan to focus on medical and nursing terms and concepts. They also noted that enough time should be given in order to learn *kanji* to help them pass the licensure examination. If they fail a second time, it will be a shame because JICWELS and their employers provided them with all the necessities for studying, including a laptop and internet access.

Others brought up the idea of having more exposure with a *sensei* (teacher), participation in end-of-shift endorsement, and access to the patient's chart. Others had wished that they be allowed to take the vital signs, get the intake and output, and give oral medications to their patients.

### Their Immediate Plans

They were indeed focused to pass the examination. This is a common sentiment among the nurse candidates. *"My feeling right now is that I really hope to pass this time. Then, my family can come and visit me here,"* one of them uttered. Except for one candidate, this will be their second attempt. If they fail again, they would still need to finish their three-year contract in order to preserve the Philippine Government's standing and reputation.

### Discussion

With the JPEPA, the Philippines has become a signatory to an economic partnership/ free trade agreement-type of treaty. The movement of natural persons is a major highlight of the JPEPA; whereby the Philippine government has a mandated policy of international labor deployment. Japan has expressed its need to have foreign nurses available for the immediate use. Since this is the first time for the Philippines to enter such a treaty, there are implications as to where this treaty would lead.

Japan has a stereotypical image of being a "land of high technology." This impression has encouraged Filipino nurses to work in technologically-advanced environs, giving them opportunities to upgrade their skills. However, given the perfunctory tasks they are allowed to perform, it turns out that

although these tasks are physically tiring, they are also extremely unchallenging and not professionally stimulating. This is similar to the findings of Ballescas (2010) involving the first batch of nurses and caregivers, who cited job-related matters such as routine work, and more importantly, the pressure to pass the board exams. The written examination in Japanese *kanji* is certainly difficult to surmount. If they are not successful in passing the examination, they will return to their country with compromised career options.

This grave concern was one of the arguments put forward by Dr. Leah Paquiz, the National President of the Philippine Nurses Association, whose term ended in 2008. The position statement stating why Filipino nurses are against JPEPA conveyed that with a Philippine license to practice nursing and "three solid years of work experience, the Filipino nurse must pass the Japanese Licensure Examination and train under the supervision of a Japanese nurse for up to three years. If the Filipino nurse is unable to pass the Japanese examination, he or she would have to be deported."

The position paper further asserted that since Filipino nurses are considered neither employees nor workers under Japan's Immigration Control Act, their rights as migrant health workers are not protected. More so, Japan cannot be obliged to commit itself to the International code of labor standards.

It is to be noted that within the second year of the JPEPA implementation in 2010, less than half of the "quota" was fulfilled. This means that out of the expected 400 nurse candidates, only 134 were deployed to Japan so far. In a study done by Yoshichica, Hirano and Ohno (2008), more than 80 percent of the respondents (directors of nursing services and directors of hospital) answered they were only a bit interested in introducing nurses to Japan, and less likely to accept foreign trainees. One probable reason is that hospital employers pay nearly 600,000 yen a month per person to JICWELS and it would be a risky investment to accept foreign nurse candidates. If they fail the examination, they will not be allowed to stay and work in Japan.

Though this finding cannot be generalized, owing to the low response rate to the questionnaire, the investigators believed that it is deemed important for the Japanese government to look closely into the provisions of the treaty and see potential loopholes.

## Conclusion

Both the Philippine and Japanese governments decided to continue consultations to improve the process of accepting Filipino nurses for employment in Japan. At present, Japanese language training is provided to nurses and caregivers in the Philippines before their dispatch to Japan. This was the result of the earlier recommendations by officials and staff hospitals and by the trainees themselves that language training be done in the country of origin. There is a strong move from the trainees, as well, that the examination be given in the English language.

Both governments also agreed to review the treaty pursuant to Article 161 of the JPEPA. Japan should learn from the experience of other countries in offering attractive incentive packages to foreign health care workers and developing support systems and integration programs that will compensate for the hard work and sacrifices they go through. The Filipino nurse candidates who were interviewed by this author were observed to be happier and were more able to adjust well in their social relationships because they get help and assistance from receiving hospitals. Our nurses are the best in the world and it is only fair and reasonable that they are treated well and provided with the work conditions and the protection that they truly deserve.

## References


Ballescas, M. R. P. *Sharing Care: Economic Partnership Agreement and Beyond*. Bulletin of Kyushu University Asia Center, vol. 5, June 2010.

Center for Migrant Advocacy Philippines, Inc. Retrieved October 20, 2011, http://japan.pinoy-abroad.net/pna_statement.htm

Movement of Natural Persons. Chapter 9, Article 108 Scope and Coverage. Retrieved October 15, 2011, http://japan.pinoy-abroad.net/jpepa_Chapter 9.pdf

Paquiz, L.P. Position Statement on the Japan-Philippine Economic Partnership Agreement (JPEPA): Why our nurses are against JPEPA.

Specific Commitments for the Movement of Natural Persons. Annex 8, Chapter 9. Retrieved October 20, 2011, http://www.mofa.go.jp/region/asia-paci/philippine/epa0609/annex8.pdf

The Philippine Daily Inquirer. *Japan okays review for Pinoy nurses.* 29 September 2011.

Understanding JPEPA: A primer. Philippine Exporters Confederation Inc. Philippine copyright 2007. Retrieved October 20, 2011. http://philexportph/jpepa/JPEPA%20Final.pdf.

Yoshichica, K., Hirano,Y.O. & Ohno, S. (2008). A Survey on Acceptance of Foreign Nurses in Japanese Hospitals. Transnational Care Studies. Kyushu University Asia Center.



*Acknowledgements*

*Dr. Fely Marilyn Lorenzo, PhD, R.N. for facilitating one of the focus group discussions conducted at the POEA on May 5, 2010.*

*Dr. Yuko Ohara-HIRANO, PhD, for inviting the author to a public forum on "Let's Learn About Nursing in Asia" held on February 28, 2011 in Osaka, Japan and facilitating her visit to hospitals that accepted Filipino nurse candidates.*

# SERVANT LEADERSHIP IN NURSING SERVICE ADMINISTRATION: THE CASE OF GOVERNMENT HOSPITALS IN PAMPANGA AND TARLAC

AL D. BIAG, *Ed.D, RN*

*Associate Professor and Program Coordinator of Holy Angel University aside from PNA and PNRS, he is also member to several national and International Organizations such as Philippine Statistical Association, STII Honor Society of Nursing, and International Confederation of Midwives Network of Research Advisors.*


ABSTRACT

*Nursing leaders contend continuously to challenges that micromanage and often thwart professional creativity. Servant leadership as an approach could address these challenges in nursing service administration. Thus, this study aimed to determine the servant leadership characterization of nursing service administrators of government hospitals in Pampanga and Tarlac. A descriptive correlational design was used. A purposive sample of 70 nurse administrators comprised the respondents. Based on the results on Servant Leadership Inventory (SLI), the majority of them have very low to low servant first orientation, average to above average receptive responsive caring, above average other centered service, and very low to low instructive transformative relating. Their age and position were significantly related to their servant leadership disposition specifically on the dimensions servant first orientation and instructive transformative relating.*

Traditionally, the purpose of nursing service administration has been to design, manage, and facilitate care delivery (Wolper, 2005). Nursing service administrators assume management and leadership roles in planning, organizing, and implementing care for people across the broad spectrum of health care settings (American Hospital Association [AHA], 1990). Positional authority and top-down leadership over staff nurse decisions and nursing practice have been the conventions of the time (Ray, Turkel, & Marino, 2002). But the ever-changing world of health care continues to present new challenges (The American Organization of Nurse Executives [AONE], 2005). To address these challenges, today's health care governance, specifically nursing administration, must employ new forms of leadership reflecting the diversity of employees and serviced communities (Scott & Caress, 2005).

This perspective calls for a leadership-for-all strategy. This strategy would help professionals take initiatives on all levels to develop health care services of the future (Jasper, 2005). As a model, leadership-for-all creates a sense of belonging within an organization, develops leaders at every level in the organization, and breaks down power relationships between and among professionals (Dallaire, 2005). It is therefore characterized as a concept of shared governance. Shared governance requires an alternative to the power-based approaches to leadership and management. Servant leadership goes well with shared governance.\

Nurse leaders have a fundamental role in the implementation of this new management model (Dallaire, 2005). But they must be drawn to a purpose greater than themselves (Downs, 2007). This is the motivation in servant leadership (Peete, 2005). The values of care and compassion associated with the dedicated bedside nurse must be congruent with nurse administrators' attitude toward stewardship and leadership (Swearinger & Liberman, 2004).

Having experienced rising from within the ranks, nursing service administrators must remember what was emphasized to them when they were just ordinary staff nurses, that caring and selfless service are always intertwined with nursing. Now that they are serving those who serve (nurses) others (patients), they should be able to apply the concept in another area.

But how prepared are the nurse administrators to adopt servant leadership? Spears (2003) contended that servant leadership characteristics often occur naturally within many individuals and can only be enhanced through learning and practice. Thus, it is the intention of this study to determine the servant leadership characteristics, practice, disposition, and potential of government hospitals' nursing service administrators.

Servant leadership is neither a new idea nor a new leadership model. In fact, it is as old as the great religions and traditions of the world (Hasselbach, 1998; Zandy, 2007). It appears to ancient writings such as the Christian Bible and Tao Te Ching dating back as early as 2500 years.

The recent popularization of servant leadership, however, is credited to Robert K. Greenleaf, a long time management researcher at AT&T and a lifelong philosopher. His idea of servant-as-leader was partly influenced by his vast experience in thinking and working on leadership and service issues (Spears, 1998). Nevertheless, he only began developing this idea after reading Herman Hesse's short novel *Journey to the East* and was able to conclude thereafter that a great leader is first seen as a servant to others.

Greenleaf's initial work on servant leadership influenced the observation, generation, and development of notable sets of attributes that describe the qualities of a servant leader. In his first essay titled *The Servant as Leader*, a servant leader is described as the one who embodies certain characteristics. These characteristics are: (1) servant first, (2) articulate goals, (3) inspires trust, (4) knows how to listen, (5) master of positive feedback, (6) relies on foresight, and (7) emphasizes personal development (Greenleaf, 1977). These characteristics became the basis of his framework for servant leadership and its accompanying basic guidelines (Lussier & Achua, 2001).

Moreover, after decades since its coinage by Greenleaf, servant leadership is currently undergoing a renaissance. With a growing and widespread adaptation by academic, business, and other institutions, and a proliferation of research appearing in refereed journals, servant leadership is moving from an anecdotal phase to the validation phase where it is supported by quantitative empirical research (Nwogu, 2004). With all these, the literature revolving around servant leadership can now generally be classified into two broad areas: theoretical and empirical (Matteson & Irving, 2006). The works of Spears (1995, 1998), Laub (1999), and Patterson (2003) are the frequently cited theoretical discussions of servant leadership. Of the three, it is Spears' work that is considered as an outgrowth of Greenleaf's servant leadership.

Notably, Spears is the President and CEO of the Robert K. Greenleaf Center for Servant Leadership. So, from his own reading of Greenleaf's work he identified a set of 10 characteristics which he ascribed to the servant leader. These include listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to growth of people, and community building.

Spears and others (Hasselbach, 1998; Rowe, 2003; Howatson-Jones, 2004; Swearinger & Liberman, 2004; Downs, 2007; Zandy, 2007) presented varied yet related descriptions of the 10 characteristics of servant leadership. The following are the syntheses of their different descriptions. Listening as a servant leader's characteristic comes from two sources: external (i.e. receptive openness to voices of the followers as regards to values, goals, mission, and vision of the institution) and internal (reflective listening to the inner voice or tuning in with the spirit within). Empathy is accepting people as they are and attempting to know them from within. Healing is having a broad view or trying to see the whole. Awareness aids in understanding issues involving ethics and values. Persuasion is getting other people do what needs to be done without coercion or force.

Conceptualization is thinking beyond day-to-day realities and having a vision of what the organization could and should be. Foresight is a characteristic that enables the servant leader to understand the lessons from the past, the realities of the present, and the likely consequence of a decision for the future. Stewardship is thinking of and preparation to transfer leadership to a succeeding generation of leaders. Commitment to growth of people emanates from the belief of the servant leader that followers have an intrinsic value beyond their tangible contributions as workers. Lastly, building community is calling followers out of isolation and self-interest and turning them into a growing and generative community.

From the seminal work of Greenleaf, the construct of servant leadership has grown obviously due to contributions of not only Spears, Laub, and Patterson but also of others (Sendjaya & Sarros, 2002; Sendjaya, 2003; Winston, 2003; Wong & Page, 2003). Consequently, this growth in the body of knowledge on servant leadership produced a number of applications in areas such as profit and not-for-profit corporations (Strickland, 2006), community leadership programs (Hamilton, 2007), trustee education, service learning, formal management/leadership courses, academe, and healthcare (Spears, 2005).

In health care, writings about servant leadership appear in physician leadership (Schwartz & Tumblin, 2002), foundation for professionalism in physical therapy education (Gersh, 2006) and in nursing leadership (Anthony, et al., 2005;

Swearinger & Liberman, 2004; Downs, 2007). Swearinger and Liberman and Downs stressed the application of servant leadership, particularly the 10 characteristics (Spears, 1998) in nursing administration to address the challenge of acute nursing shortage brought by high staff turnover, job dissatisfaction, lower wages, and voluminous regulations that micromanage and often thwart professional creativity.

### Statement of the Problem

This study determined the extent of servant leadership among nursing service administrators of government hospitals in Pampanga and Tarlac.

Specifically, it sought to answer the following:

1. How are the nursing service administrators described as to their personal and professional attributes in terms of age, gender, highest educational attainment, length of service as administrator, position, and rank?
2. To what extent do the nursing service administrators exhibit the servant leadership characteristics in the following dimensions: servant-first orientation; receptive-responsive caring; other-centered service; and instructive-transformative relating?
3. How do the nursing service administrators' personal and professional attributes relate to their characterization of servant leadership?

## METHODS

### Research Design

The study utilized a quantitative research design particularly descriptive correlational type. The personal and professional attributes of the nursing service administrators such as age, gender, highest educational attainment, length of service as administrator, position, and rank and the servant leadership characteristics of servant first orientation, receptive-responsive caring, other-centered service, and instructive-transformative relating were described and determined as correlates.

### Study Setting and Sampling

The study was conducted in 16 government hospitals in the provinces of Pampanga and Tarlac. These government hospitals are classified as local government-owned, community, district, provincial and regional hospitals. A total of 12 hospitals in Pampanga and four hospitals in Tarlac were covered in the study. Purposive sampling and total sample enumeration were utilized to obtain the desired number (n=70) of nursing service administrators as respondents.

*Table 1*
*Government Hospitals in Pampanga and Tarlac*

| Hospitals | Location |
|---|---|
| 1. Balitucan District Hospital | Magalang, Pampanga |
| 2. Diosdado Macapagal Memorial Hospital | Guagua, Pampanga |
| 3. Dr. Emigdio C. Cruz, Sr. Memorial Hospital | Arayat, Pampanga |
| 4. Escolastica Romero District Hospital | Lubao, Pampanga |
| 5. Jose B. Lingad Memorial Regional Hospital | City of San Fernando, Pampanga |
| 6. Mabalacat District Hospital | Mabalacat, Pampanga |
| 7. Macabebe District Hospital | Macabebe, Pampanga |
| 8. Porac District Hospital | Porac, Pampanga |
| 9. Rafael Lazatin Memorial Hospital | Angeles City |
| 10. Romana Pangan District Hospital | Floridablanca, Pampanga |
| 11. R.P. Rodriguez Memorial Hospital | Bulaon Resettlement Site, CSF, Pamp. |
| 12. San Luis District Hospital | San Luis, Pampanga |
| 13. Camiling District Hospital | Camiling, Tarlac |
| 14. Concepcion District Hospital | Concepcion, Tarlac |
| 15. La Paz Community & Medicare Hospital | La Paz, Tarlac |
| 16. Tarlac Provincial Hospital | Tarlac City |

### Research Instrument

The Servant Leadership Inventory (SLI) was used to collect data from the respondents. It is a 50-item self-report instrument that contains the 10 servant leadership characteristics clustered into four dimensions namely: servant-first orientation (servant-first and conceptualization); receptive-responsive caring (awareness, listening, empathy and healing); other-centered service (stewardship and commitment to growth of people); and instructive-transformative relating (persuasion and community building).

The construct validity of the instrument was determined through factor analysis and contrast groups method. The *t*-test of the total scores of the two contrast groups and every item of the SLI showed significant difference. The reliability of the SLI is determined by the Cronbach alpha and the test-retest method and both procedures have yielded high reliability coefficient of 0.891823 and 0.9084 respectively. The norms of the SLI are constructed by percentile ranks, and interpreted as Superior, High Average, Above Average, Average, Below Average, Low, and Very Low. SLI was developed by Sr. Merceditas O. Ang, SPC and distributed exclusively by Mavec Specialists Foundation Inc.

## Ethical Consideration

The University Research Council of Holy Angel University did the technical and ethical review of the study. Participation was voluntary among the prospective participants and answering the questionnaire implied consent. The letter of intent sent to departments of nursing service of the hospitals discussed matters concerning the purpose of the research, identity and credentials of the researcher, and guarantee of anonymity and confidentiality. The latter was emphasized further in the cover letter of the questionnaire as there was no identifying information required to the participants.

## Data Analysis

A summary of the frequency and percentage of individual values and ranges of values for variables like personal and professional attributes of the nursing service administrators as well as their scores on SLI will be presented as part of analysis of data.

To test correlations between the respondents' attributes and their scores on the four dimensions of servant leadership, Spearman *ñ* and exact test were performed through the *Statistical Package for the Social Sciences* (SPSS) version 11 and *Simple Interactive Statistical Analysis* (SISA).

## RESULTS

## Sample Characteristics

The sample (*N* = 70) consisted of senior nurses, nurse supervisors, assistant chief nurses, and chief nurses who comprise the nursing personnel collectively referred to in this study as the nursing service administrators. Table 2 presents the personal and professional attributes of nursing service administrators. In terms of age and gender, most of them belong to belong to 50 59 years old bracket (50%) and are females (97.1%).

As regards their professional characteristics like highest educational attainment, 20 percent of them are already possessing master's degree while the majority is bachelor's degree holders with (44.3%) or without units (34.3%) in the master's degree. Their length of service is variably described as 10 years and below (24.3%), 11-20 years (35.7%), 21-30 years (34.3%), and 31-40 years (5.7%). The nursing service administrators occupy positions such as senior nurse (45.7%), nurse supervisor (27.1%), assistant chief nurse (4.3%), and chief nurse (22.9%) with corresponding ranks ranging from Nurse I to Nurse VII. The rank Nurse VII is assigned to a chief of a regional hospital while the rank Nurse VI (2.9%) is assigned to chief nurses of tertiary hospitals. Nurse V (4.3%) is the rank of assistant chief nurses of tertiary hospitals while Nurse IV (18.6%) is the rank of chief nurses of secondary hospitals. Nurse III (17.1%) is rank of nurse supervisors while Nurse II (48.6%) is the promotional rank for senior nurses. However, it must be noted that there senior nurses who are still holding a Nurse I rank (7.1%).

*Table 2*

*Distribution of nursing service administrators according to their personal and professional attributes*

| Attributes | f | % | Attributes | f | % |
|---|---|---|---|---|---|
| Age | | | Position | | |
| 30-39 years old | 10 | 14.3 | Senior Nurse | 32 | 45.7 |
| 40-49 years old | 22 | 31.4 | Nurse Supervisor | 19 | 27.1 |
| 50-59 years old | 35 | 50.0 | Assistant Chief Nurse | 3 | 4.3 |
| 60 years old and above | 3 | 4.3 | Chief Nurse | 16 | 22.9 |
| | 70 | 100.0 | | 70 | 100.0 |
| Gender | | | Rank | | |
| Male | 2 | 2.9 | Nurse I | 5 | 7.1 |
| Female | 68 | 97.1 | Nurse II | 34 | 48.6 |
| | 70 | 100.0 | Nurse III | 12 | 17.1 |
| | | | Nurse IV | 13 | 18.6 |
| Educational Attainment | | | Nurse V | 3 | 4.3 |
| Bachelor's degree | 24 | 34.3 | Nurse VI | 2 | 2.9 |
| With units in masterate | 31 | 44.3 | Nurse VII | 1 | 1.4 |
| With masterate degree | 14 | 20.0 | | 70 | 100.0 |
| With units in doctorate | 1 | 1.4 | | | |
| | 70 | 100.0 | | | |
| Length of Service | | | | | |
| 1-10 years | 17 | 24.3 | | | |
| 11-20 years | 25 | 35.7 | | | |
| 21-30 years | 24 | 34.3 | | | |
| 31-40 years | 4 | 5.7 | | | |
| | 70 | 100.0 | | | |

Table 3 presents the distribution of nursing service administrators according to servant-first orientation. Collectively, a considerable percentage (61.5%) of them has low levels (i.e. very low to below average) of servant-first orientation.

The nursing service administrators with average level of servant-first orientation are likely to exhibit servant-first orientation in their workplace. They easily volunteer their

services and they give good examples to their subordinates. They could also communicate their ideas and feelings with less difficulty and compromise of their values and principles. They see themselves as servants at heart therefore serving is their ambition and mission in life. In terms of group undertaking, they set the direction and purpose as they nurture dreams and visions of great things to come. Consequently, they succeed in any endeavor but this does not flatter them for they lead with moral authority and personal integrity

. The nursing service administrators with high to superior levels of servant-first orientation very often practice servant-leadership and manifest the traits of a servant leader, particularly humble, loving, ethical, and unconditional service. Their kind of leadership is primarily attuned towards servanthood rather than a mandate of power and authority; hence their purpose in leading is to be able to serve.

Those with low levels of servant-first orientation are more likely (at varying levels) to still get excited over getting promotions and awards. In relation with this, they are threatened when somebody is considered as better than them. When committing faults and mistakes, they are a bit ashamed to admit and apologize. A martyr image too is not appealing because for them having a position warrants subordinates to follow them always. Consequently, they treat people according to their status and position.

Table 4 presents the distribution of nursing service administrators according to receptive-responsive caring dimension of servant leadership. Generally, they strongly manifest this servant leadership dimension with a majority of the respondents (58.6%) having above average to superior levels of receptive-responsive caring.

Receptive-responsive caring pertains to the leader's ability to give quality care by being receptive to the nature and particular circumstances of the recipients and knowing their needs and concerns, thus being able to respond accordingly. This involves basic awareness, perceptivity, and sensitivity of inputs coming from both internal and external sources; listening to the minds and hearts of people; empathizing with people and finding meaning in their experiences; healing and compassionate presence; and anticipating the needs of others.

The nursing service administrators with above average to superior receptive-responsive caring believe they are leaders because of their ability to take chances for success with the risk of failure. They learn from the past, understand the reality of the present, and think of the future consequences of a decision. Because they listen with their heart, they give due consideration for the feelings and opinions of others and deal with issues based on what is right. In terms of supervision, they do it with kindness and understanding putting importance on the person's "being" more than his or her "doing". On the personal level, they give quality caring to everybody regardless

*Table 3*
*Distribution of nursing service administrators according to the extent of their servant first orientation*

| Classification | Frequency | Percentage |
|---|---|---|
| Very Low | 31 | 44.3 |
| Low | 6 | 8.6 |
| Below Average | 6 | 8.6 |
| Average | 25 | 35.7 |
| High | 1 | 1.4 |
| Superior | 1 | 1.4 |
| Total | 70 | 100.0 |

*Table 4*
*Distribution of nursing service administrators according to the extent of their receptive responsive caring*

| Classification | Frequency | Percentage |
|---|---|---|
| Low | 1 | 1.4 |
| Below Average | 2 | 2.9 |
| Average | 26 | 37.1 |
| Above Average | 13 | 18.6 |
| High | 19 | 27.1 |
| Superior | 9 | 12.9 |
| Total | 70 | 100.0 |

of gender, color, status, religion, and political beliefs. They provide for the needs of others more than their own thereby experiencing wholeness and well-being in serving others.

In addition to these, nursing service administrators with superior receptive-responsive caring are almost always receptive and responsive in giving quality care to the people they deal with. They are very much aware of the needs and concerns of the people they care for. They listen to them and empathize with their experiences and sentiments.

*Table 5*
*Distribution of nursing service administrators according to the extent of their other centered service*

| Classification | Frequency | Percentage |
|---|---|---|
| Average | 4 | 5.7 |
| Above Average | 40 | 57.1 |
| High | 21 | 30.0 |
| Superior | 5 | 7.1 |
| Total | 70 | 100.0 |

Table 5 presents the distribution of nursing service administrators according to other-centered service dimension of servant leadership. The table shows that they ardently exhibit this dimension with almost all of the respondents (94.2%) having above average to superior levels of other-centered service.

Other-centered service pertains to the services of the leader that are geared to benefit others and not for self-serving interests. The emphasis is on the responsibility of the leader to serve the needs of the people and the society at large. This orientation considers the organization as an instrumentality of providing services and sharing of resources to improve the quality of life, and that the leader is impelled by social consciousness, altruistic reasons, and honest motives.

The nursing service administrators with above average to superior other-centered service are more likely put the interest of others above their own. They usually prioritize the needs of others and channel their efforts to benefit the greater majority of their constituents. They also consider themselves as caretaker and not owner of things attached to their position. Therefore, they share resources and make them available for the use of others. They have the strong tendency to develop others to become leaders which in turn results to empowerment and building confidence in them.

*Table 6*
*Distribution of nursing service administrators according to the extent of their instructive transformative relating*

| Classification | Frequency | Percentage |
|---|---|---|
| Very Low | 29 | 41.4 |
| Low | 11 | 15.7 |
| Below Average | 4 | 5.7 |
| Average | 21 | 30.0 |
| High | 5 | 7.1 |
| Total | 70 | 100.0 |

Table 6 presents the distribution of nursing service administrators according to instructive-transformative relating dimension of servant leadership. Most of them (57.1%) have very low to low levels while a sizeable percentage of them (30%) have average level of instructive-transformative relating.

Instructive-transformative relating refers to the leader's way and manner of relating with people and dealing with issues. Human relations are founded on values and virtues that are taught by example and intended to create a transforming effect on others. This speaks of the leader's ability to communicate a vision of what the organization can do, and what the individual members can contribute towards the fulfillment of organizational goals and objectives. The leader develops his or her people to be successful and empowers them in the process.

The nursing service administrators with very low to low levels of instructive-transformative relating are less likely to undertake wide consultation first before deciding or changing some things. Since they are not good follower and team player, they are less tolerant to people with difficult characters. They seldom use gentle words in persuading others and do not resort to imagination and creativity as means to convince subordinates to accomplish something.

The average level instructive-transformative relating nursing service administrators' human relations can sometimes impart values and virtues which, in effect, create a transforming effect on people. They also empower subordinates and develop leaders to a certain extent. In a limited way, they envision the role of their institutions in social transformation and values formation of their subordinates.

Table 7 presents the correlations between the nursing service administrators' personal/professional attributes and their servant leadership characterization. The statistical analyses show that the correlations are not significant with the exception of age and servant first orientation (.019); age and instructive transformative relating (.029); and position and servant first orientation (.004). Since the correlations are direct (positive), these suggest that nursing service administrators who are more senior in age and position are more likely to exhibit servant first orientation and instructive transformative relating. Nevertheless, the relatively weak magnitudes of correlations (.280, .261, and .338, respectively) denote that age and position are the only ones contributing to altruistic or selfless leadership.

## DISCUSSION

This study investigates the servant leadership characterization of nursing service administrators of government hospitals in Pampanga and Tarlac. These nursing service administrators are mostly middle-aged (middle adults) and female. They possess the minimum educational qualification for their respective positions and have served the institutions at varying lengths of time.

They have shown a moderate sense of servant first orientation and instructive transformative relating. Their leadership can sometimes manifest the traits of a servant leader, in a limited way, particularly humble, loving, ethical, and unconditional service. Their human relations can sometimes impart values and virtues which, in effect, create a transforming effect on people.

They exhibit a high sense of receptive responsive caring. They as leaders are almost always receptive and responsive in giving quality care to the people they deal with. They are very

*Table 7*
*Correlation of the nursing service administrators' personal and professional characteristics with their servant leadership characterization*

| Personal and Professional Attributes | Servant First Orientation | Receptive Responsive Caring | Other Centered Service | Instructive Transformative Relating |
|---|---|---|---|---|
| Age | .019* (.280) | .108 | .843 | .029* (.261) |
| Gender | .321 | .096 | .086 | .095 |
| Educ. Attainment | .716 | .832 | .881 | .865 |
| Length of Service | .798 .004** | .541 | .467 | .755 |
| Position | (.338) | .122 | .066 | .668 |
| Rank | .226 | .158 | .166 | .168 |

*** Correlation is significant at the .01 level (2-tailed).* *** Correlation is significant at the .05 level (2-tailed).*

much aware of the needs and concerns of the people they care for. They also ardently exhibit other centered service because of their tendency to prioritize the needs of other and to channel their efforts to benefit a greater majority.

Nursing service administrators who are senior in age and position seem to exhibit higher servant first orientation and instructive transformative relating.

## Conclusion

The service orientation of nursing as imbibed and as demonstrated in the professional life of the nursing service administrators came out as expected in their servant leadership characterization. The study results add to the research evidence showing that servant leadership characteristics often occur naturally within many individuals and can be enhanced through learning and practice. The results suggest that, at the very least, nursing service administrators can learn further the tenets of servant leadership by adhering to its set of concepts and by actions that occur from a direct result of modelling these concepts and can practice it by incorporating the same ideas with their performance of management functions.

## Implications

The philosophy of servant leadership can be of great benefit in the government hospital setting as it effectively addresses the needs of nurses who are accustomed to service-oriented practice and are involved in serving the community's neediest residents. But these nurses must be nurtured by nursing administrators who are themselves servant leaders. As servant leaders, they should develop a greater awareness of themselves as part of the caregiver and leadership continuum, rather than perceiving themselves mainly as gatekeepers who must control and manage all the problems inherent in the nursing service department. More than an inherent attribute, servant leadership should be a part of nursing service administration. Administrators should embrace it as a style so that they can recognize individuality and empower nurses to find the necessary balance between supporting their institution, their patient's welfare, and their own development.

## Recommendations

Other directions for future research include correlational analysis of servant leadership practices and disposition with other constructs such as staff turnover, job satisfaction, patient satisfaction, etc. or an alteration of the design by employing a multisource assessment or a qualitative inquiry. Likewise, researches may be undertaken on servant leadership as a core strategy or as a continuous quality improvement/quality assurance strategy; servant leadership versus performance of individual, unit/division, or organization; and inclusion of private hospitals as comparators with government hospitals.

## References

American Hospital Association. (1990). *Management advisory: Role and functions of the hospital nurse executive*. Chicago: American Hospital Association.

American Organization of Nurse Executives. (2005). *AONE Nurse executive competencies*. Retrieved November 05, 2007, from www.aone.org/pdf/February%20Nurse%20Leader---final%20draft--for%20web.pdf.

Anthony, M. K., Standing, T. S., Glich, J., Duffy, M., Paschall, F., Sauer, M. R., Sweeney, D. K., Modic, M. B., & Dumpe, M. L. (2005). Leadership and nurse retention: The pivotal role of nurse managers. *Journal of Nursing Administration 35* (3) , 146-155.

Dallaire, C. (2005, March). Nursing service administration: Current

and future research issues. *Document prepared for the Committee of Strategic Development*. Retrieved November 05, 2007, from www.ferasi.umontreal.ca/fra/07_info/Rapport%20traduction%20ENG%20mars%2006.pdf.

Downs, F. C. (2007). The servant-leadership worldview in long-term nursing. *Annals of Long-Term Care, 15* (8) , 36-39.

Gersh, M. R. (2006). Servant-leadership: A philosophical foundation for professionalism in physical therapy. *Journal of Physical Therapy Education, Fall 2006* . Retrieved November 06, 2007, from http://findarticles.com/p/articles/mi_qa3969/is_200610/ai_n18622048.

Greenleaf, R. K. (1977). *Servant-leadership: A journey into the nature of legitimate power and greatness*. Mahwah, NJ: Paulist Press.

Hamilton, F. (2007). Servant-leadership: Organizing communities to solve a challenge. *PA Times 30* (5) , 5, 8. Washington, DC: American Society for Public Administration.

Hasselbach, R. E. (1998). Renaissance thinking: Servant leadership and higher education. *Renaissance Administrator, 1* (1) , 3-7.

Howatson-Jones, I. L. (2004). The servant leader. *Nursing Management, 11* (3) , 20-24.

Jasper, M. (2005). Managing and leading a nursing workforce. *Journal of Nursing Management 13* (1) , 1-3

Laub, J. (1999). Assessing the servant organization: Development of the servant organization (SOLA) instrument. *Dissertation Abstracts International, 60* (02) , 308. (UMI No. 9921922).

Lussier, R. N., & Achua, C. F. (2001). *Leadership theory application skill development*. Cincinnati, OH: South-Western College Publishing.

Matteson, J. A., & Irving, J. A. (2006). Servant versus self-sacrificial leadership: A behavioral comparison of two follow-oriented leadership theories. *International Journal of Leadership Studies, 2* (1) , 36-51. Retrieved October 06, 2007, from http://www.regent.edu/acad/global/publications/ijls/new/vol2iss1/matteson/mair.pdf.

Nwogu, O. G. (2004). Servant leadership model: The role of follower self-esteem, emotional intelligence, and attributions on organizational effectiveness. *Proceedings of the Servant Leadership Research Roundtable*. Retrieved October 06, 2007, from http://www.regent.edu/acad/sls/publications/conference_proceedings/servant_leadership_roundtable/2004pdf/nwogu_servant_leadership.pdf.

Patterson, K. (2003). Servant leadership: A theoretical model. *Dissertation Abstracts International, 64* (02) , 570. (UMI No. 3082719).

Peete, D. (2005). Needed: Servant leaders. *Nursing Homes: Long Term Care Management 54* (7). Retrieved October 31, 2007, from www.allbusiness.com/human-reources/workforce-management/502405-1.html.

Ray, M., Turkel, M., & Marino, F. (2002). The transformative process for nursing in workforce development. *Nursing Administration Quarterly, 26* (2) , 1-4.

Rowe, R. (2003). Leaders as servant…The 10 key characteristics. *New Zealand Management, 50* (1) 24-25. Retrieved October 06, 2007, from http://www.management.co.nz.

Schwartz, R. W., & Tumblin, T. F. (2002). The power of servant leadership to transform health care organizations for the 21st century economy. *Archives of Surgery, 137* (12) , 1419-1427. Retrieved November 06, 2007, from http://www.ncbi.nlm.nih.gov/sites/entrez?and=Retrieve&db=PubMed&list_uids=12470112&adopt=Abstract.

Scott, L., & Caress, A. L. (2005). Shared governance and shared leadership: Meeting the challenges of implementation. *Journal of Nursing Management 13* (1) , 4-12.

Sendjaya, S. (2003). Development and validation of Servant Leadership Behavior Scale. *Proceedings of the Servant Leadership Roundtable*. Retrieved October 06, 2007, from http://www.regent.edu/acad/global/publications/sl_proceedings/2003/sendjaya_development_validation.pdf.

Sendjaya, S., & Sarros, J. C. (2002). Servant leadership: Its origin, development, and application in organizations. *Journal of Leadership and Organization Studies, 9* (2), 57-64.

Spears, L. C. (1995). Servant leadership and the Greenleaf legacy. In L. Spears (Ed.), *Reflections on leadership: How Robert K. Greenleaf's theory of servant-leadership influenced today's top management thinkers* (pp. 1-14). New York: John Wiley & Sons.

Spears, L. C. (1998). *Insights on leadership: Service, stewardship, spirit, and servant-leadership*. New York: John Wiley & Sons.

Spears, L. C. (2003). *Servant leadership: Quest for caring leadership*. Greenleaf Center for Servant Leadership. Retrieved October 31, 2007, from http://greenleaf.org/leadership/read-about-it/Servant-Leadership-Articles-Book-Reviews.html.

Spears, L. C. (2005). The understanding and practice of servant-leadership. *Proceedings of the Servant Leadership Research Roundtable*. Retrieved November 02, 2007, from http://www.regent.edu/acad/sls/publications/conference_proceedings/servant_leadership_roundtable/2005/pdf/spears_practice.pdf.

Spencer, J. L. (2007). The new frontier of servant leadership. *Proceedings of the Servant Leadership Research Roundtable*. Retrieved October 06, 2007, from http://www.regent.edu/acad/global/publications/sl_proceedings/2007/spencer.pdf.

Strickland, S. A. (2006). Not-for-profit organizational leaders' self-perception of servant leadership characteristics (Doctoral dissertation, Capella University). *Dissertation Abstracts International, 206*, DAI-A 67/02.

Swearinger, S., & Liberman, A. (2004). Nursing leadership: Serving those who serve others. *The Health Care Manager, 23* (2), 100-109.

Winston, B. E. (2003). Extending Patterson's servant leadership model: Explaining how leaders and followers interact in a circular model. *Proceedings of the Servant Leadership Research Roundtable*. Retrieved November 03, 2007, from http://www.regent.edu/acad/global/publications/sl_proceedings/2003/winston_extending_patterson.pdf.

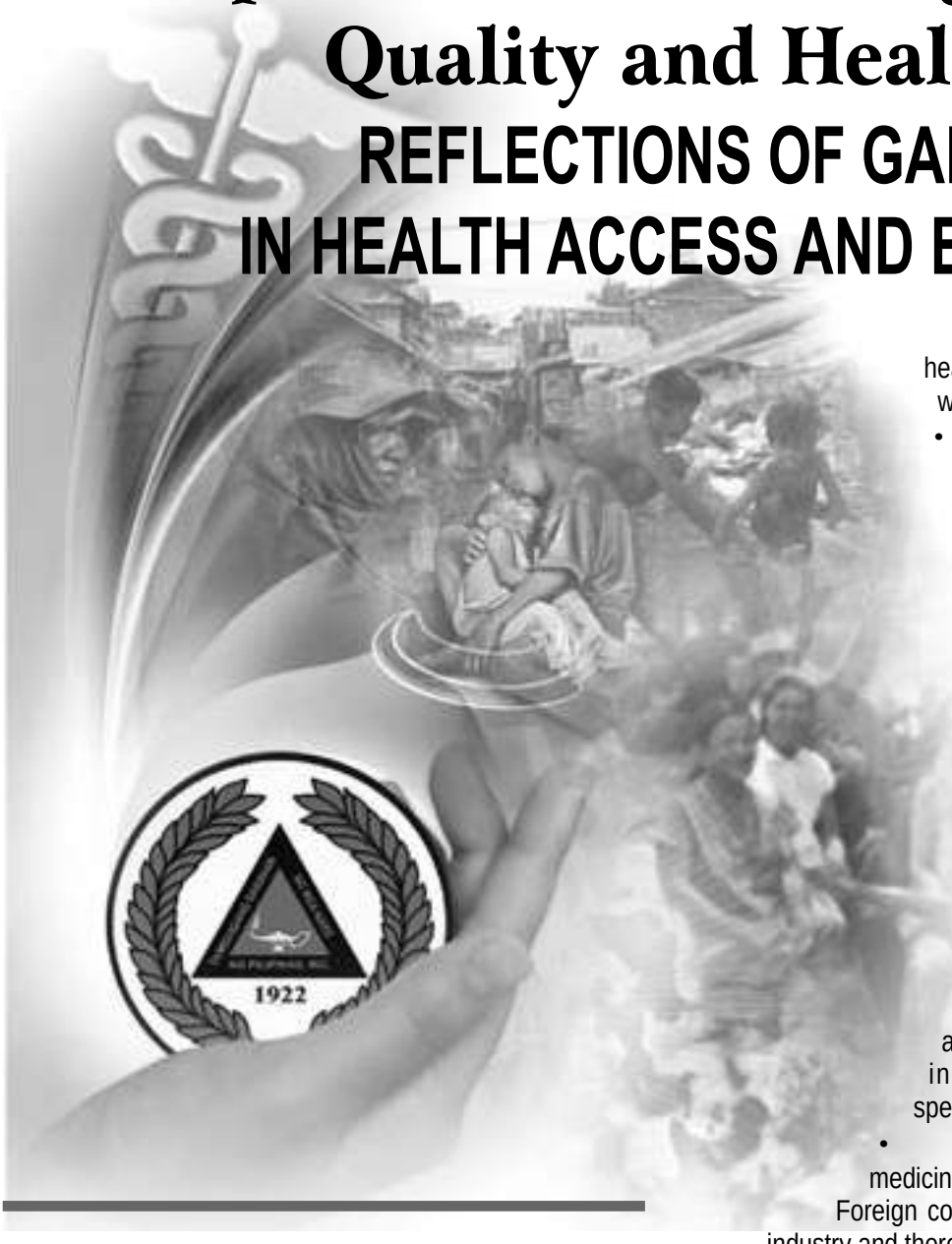
Wolper, L. F. (2005). *Health care administration: Panning, implementing, and managing organized delivery systems*. 4th ed. Boston: Jones and Bartlett.

Wong, T. P., & Page. D. (2003). Servant leadership: An opponent-process model and the revised servant leadership profile. *Paper presented at the Servant Leadership Research Roundtable*. Retrieved October 06, 2007, from http://www.regent.edu/acad/sls/publications.

Zandy, A. (2007). If you want to lead…Learn to serve. *Debt Cubed 22* (4) , 24-25. Retrieved October 06, 2007, from http://www.leadersresourcentework.com.

# Filipino Nurses Driving Access, Quality and Health:

## REFLECTIONS OF GAPS IN HEALTH ACCESS AND EQUITY




The Health Care Gaps in Statistics

- According to the World Health Organization, there should be one doctor for every 600 people. In the USA, there is one doctor for every 450 Americans. In Cuba, there is one for every 225 Cubans. But in the Philippines, there is one for every 28,000 Filipinos.
- In 2007, among the poorest 30% of the population in the Philippines, for every 100 families, 35 do not have safe drinking water and 30 do not have a toilet.
- In far-flung areas of the Cordillera Region, the nearest health center is one-hour or two-day walk away.
- Out of the PhP 1.645T national budget for 2011, the budget for the Department of Health (DOH) is only 2.35% or PhP 32.6B. This translates to P0.70/person. It is 7th in rank in allocation. The first in allocation is debt-servicing (P357 billion) and the second is for the Department of National Defense (86% increase to PHP104.5 billion)
- Because of the reduction in the budget for health for this year, the budget for12 major public hospitals is reduced by PhP 318M, the budget for 55 government hospitals nationwide by P363.7M and the budget for subsidy for indigent patients for use of specialized equipment, by 20M.
- In the Philippines, expensive medicines must come with a prayer. Foreign companies control 72% of the drug industry and therefore, the price of drugs. Because of this, even if local production cost of drugs are low, the actual retail price is high. For example, for Amoxycillin 500 mg, the manufacturing cost is only PhP 1.49, but the retail price is PhP 22.00.
- One government policy detrimental to health is the privatization of government hospitals because under privatization, the primary motive is profit and not public service. Today, there are 15 hospitals being privatized. Among these are very important national hospitals such as the Philippine Heart Center, the Lung Center of the Philippines, the National Kidney

and Transplant Institute, the National Center for Mental Health, the Philippine Orthopedic Hospital, and the National Children's Hospital.

- The Philippines is the no. 1 exporter of nurses worldwide with 85% of Filipino nurses working in some 50 countries.1 Every month more than 2,000 nurses leave the Philippines to work abroad2. More than 9,000 doctors have already left as nurses from 2002 to 2005.3 Other professionals like dentists, physical therapists, medical technologists, lawyers, engineers are taking up nursing courses to work as nurses abroad. An estimated 15,000 health professionals leave the country annually for employment abroad.
- For the past five years, about 50% of nurses employed in specialty hospitals like Philippine Health Center, National Kidney & Transplant Institute, Lung Center of the Philippines & Philippine Children's Medical Center went abroad. They are replaced by new nurses, who are also applying for abroad but just finishing few years experience as requirements.
- "Doctors becoming nurses" is a new phenomenon which result to the depletion of doctors. Ninety percent (90%) of Municipal Health Officers, these are doctors working in rural health centers, are taking up nursing and expected to leave the country. Anesthesiologists and obstetricians are rapidly depleting, followed by pediatricians and surgeons.
- In this era of imperialist globalization, countries like United States of America, United Kingdom and other developed countries, thrives on cheap labor of the third world countries like the Philippines. There are about 10 million Filipinos including health professionals who live and work in 197 countries. The globalization of labor has been accepted thru the World Trade Organization's specific provisions, the General Agreement on Trade in Services (GATS) which sets down disciplines and provides the most effective framework to pursue liberalization of trade in services. GATS encourages industrialized countries to poach the brightest and the best from poor countries while protecting their own.

Health workers suffer from unjust working conditions

- To provide better patient care, a nurse should take care of 15 patients for an 8-hour shift. But nurses in the Philippines take care of up to 150 patients per shift.

Starvation wages and denied benefits

- Health workers are among the most overworked workers in the world, yet, salaries remained at starvation level. Their salaries cannot afford them decent, health and humane living conditions. Nurses receive a salary of P6,000 (US$130) in private hospitals, P12,026 (US$261) in government hospitals per month. A resident physician in a government hospital earns P19, 168 (US$417)/month. This is way below the monthly cost of living of P27,100 (US $565) for a family of 6. Health workers are deprived of economic benefits due them, such as overtime pay, night shift differential, housing allowance and holiday pay. Meager amounts are given for subsistence, clothing and laundry allowances. Health workers have to struggle earnestly for those benefits. These are despite the fact that all these benefits are mandated by law.

Health workers suffer from job insecurity

- The government implements reorganization and streamlining programs resulting to mass lay-off and job insecurities among health workers. In state hospitals, operations and maintenance are now privatized or are under contract to private companies. The security service, dietary, pharmacy, laundry, engineering and maintenance are contracted out first. Former regular employees in these services, if not removed became contractual workers. Nurses also become contractual workers.
- Government agencies say that we have an "oversupply of nurses". But aside from understaffing in the hospitals, there are so many doctorless and nurse-less barangays throughout the country, because there are no plantilla positions available or no takers if ever there are available positions. The supposed "oversupply" - which is actually "unemployment," results to exploitation by hospitals both in the private and public sector through "volunteer" work and "trainings" in exchange for exorbitant fees. In reality however, these "volunteers" and "trainees" were in most cases made to cover for the understaffing of hospitals.

Health workers' basic rights curtailed. To ensure more income, owners and hospital management find ways to control the workers even if their basic democratic rights are trampled upon. Freedom of expression is suppressed. Contractual health workers are prevented from joining unions or organizations while legitimate workers' unions are being busted. Some management refuses to negotiate with duly accredited health workers union. Union leaders are harassed. Policies, regulations and strict work procedures are

implemented to hinder the movement or curtail freedom of workers. Hospital management intervenes by promoting and actually establishing pro-management & yellow unions.

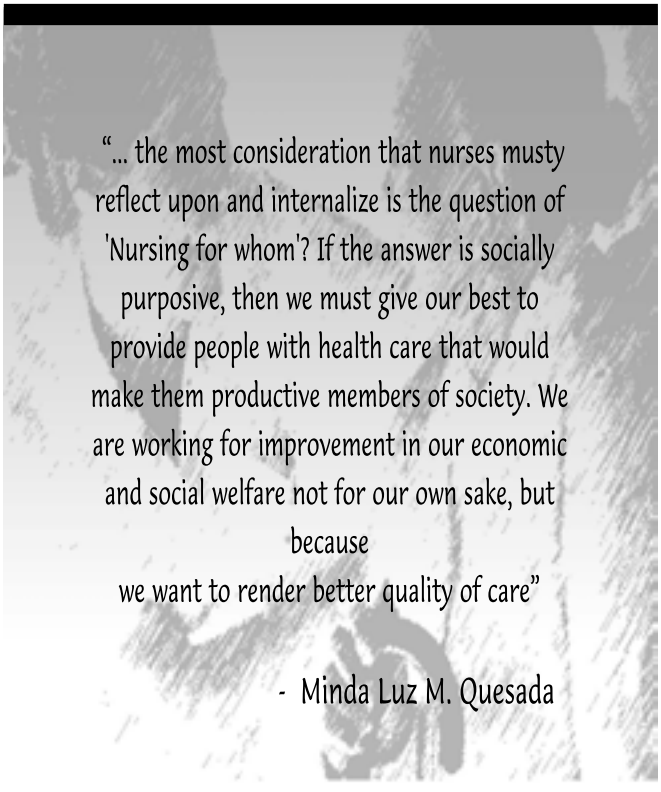
- The Philippine government is not worried on the exodus of health professionals, even encourages it. The DOH response is not to stop the brain drain. The government agencies seem helpless with the sprouting of substandard profit-oriented nursing schools in response to increased demands for nurses abroad. The western-oriented and commercialized curriculum is even being modified to further "prepare" nurse graduates in working broad by introducing subjects like "Nihonggo" as electives, and others.

## Abuses and Exploitation of Health Workers & Professionals Abroad

- Growing number of health professionals going abroad end up working as nanny, health care givers in home care institutions or live-in care givers. In Canada, Filipino Nurses are recruited to work as registered nurses through the Live-in Caregiver Program that forces them to work as 24-hour domestic workers who clean, cook and care for the children, elderly of the middle & upper class Canadian families.11
- In the United Kingdom, foreign nurses are made to pay their employer or recruitment agency for the opportunity to work. Worse, they are put on the lowest rung of the ladder, equivalent to health care assistants, while they are still processing their registration as professional nurses. After they receive their UK registration, their salary is adjusted to a level with UK trained staff.12
- In the USA, some health professionals become victims of illegal recruitment, like the case of the 27 victims of Sentosa Recruitment Agency in New York. Upon arriving in the US, the 26 nurses and 1 physical therapist were duped into working as agency nurses rather than as direct-hire staff nurses, had their wage rates lowered considerably and withheld over long periods of time, their green cards withheld, and were maltreated and abused by Sentosa affiliate hospitals and nursing homes for which they worked. When they resigned upon realizing their exploitative conditions, they were charged with criminal and administrative charges by the hospitals and nursing homes together with Sentosa. The case of illegal recruitment filed against Sentosa in the Philippine Overseas Employment Administration was dismissed after a government official intervened.
- In some other countries especially in the Middle East, many nurses complained of a series of promises over salaries and accommodation that have been broken twice over by recruiters and employers. In fact, contract substitution is the norm. They claim their housing costs have been raised in spite of their contract to include electricity, gas and council tax. The nurses also report that the free airfare promised by the recruitment agency is now being deducted from their salaries. There are also reports of bullying. Nurses were not provided with job descriptions and some employers have asked to be paid if the nurse leaves before the end of three years, even though they had only agreed to work for two. They encountered problems of being asked to sign new contracts that will commit them to less pay and more work, including some domestic duties.
- On 6 February 2010, 43 Philippine medical practitioners and health workers, known commonly as the "Morong 43," were illegally arrested by heavily armed elements of the Armed Forces of the Philippines (AFP) and police while participating in a one week First Responders Training, sponsored by the Community Medicine Foundation, Inc. and the Council for Health and Development at the farm of Dr. Melecia Velmonte located in Bgy. Maybangcal, Morong, Rizal. Dr. Velmonte is a respected infectious disease specialist as well as a consultant at the Philippine General Hospital and her farm is a regular venue for medical health trainings that attract community workers, hospital staff and academicians.
- Contrary to constitutional and international law, the health workers known commonly as the "Morong 43" were detained incommunicado without access to legal counsel or visits from their families for their first two days in military custody. Moreover family members, legal representatives, medical doctor, priest or religious minister chosen by the 43 health workers continue to face difficulties in gaining access to visit the detained health workers, including five individuals held in solitary confinement.
- On April 4, 2011, former detainees and members of the Morong 43 formally filed a civil case against top ranking government and military officials believed to be behind the gross injustices they were made to suffer in the 10 months that they were unlawfully detained. The health workers said that they are taking on a new chapter in their quest

for justice. "We want to send a strong message that one cannot just get away with human rights violations. This is our contribution to efforts in making sure that human rights violators are made accountable for their actions," Liberal, one of the plaintiffs, said. April 4 happens to be the birthday of Pres. Gloria Macapagal-Arroyo under whose administration the illegal arrest happened.

- Last March 17, 2011, CHESTCORE or the Community Health Education, Services and Training in the Cordillera Region launched a campaign to "Stop the Harassment of Cordillera Health Workers and Assert the People's Right to Health" as it exposed harassment of its staff and volunteers that already reached death threats. In recent months, the 30-year old institution experienced escalating intimidation, surveillance of its staff, its office and its fieldwork.
- On March 17, 2011, the Community Health Education, Services and Training in the Cordillera Region or CHESTCORE filed with the Commission on Human Rights Cordillera nine (9) cases of harassment it has collated since 2007. Three of these are individual cases, five (5) happened in Kalinga where Chestcore's work concentrated for the past two years, and one on the surveillance of its office.
- Last November, 2010, one of the nation's foremost botanists, Leonardo Co, died ironically where he was most comfortable, inside a forest teeming with indigenous trees. Unknown to him, danger was camouflaged in the thick vegetation. He and two other companions, forest guard Sofronio Cortez and farmer Julius Borromeo, were killed in a hail of gunfire coming from Army soldiers who his family believes mistook the research team for New People's Army (NPA) rebel. Unknown to many, Leonard Co was a staff of a Baguio-based health institution, the Community Health Education, Services and Training in the Cordillera Region or CHESTCORE in the 80's.
- Leonard Co, one of the country's foremost botanists, who was mistaken for an NPA and killed in Leyte last November 2010, helped the Community Health Education, Services and Training in the Cordillera Region or CHESTCORE publish a very valuable book: "Common Medicinal Plants of the Cordillera Region" in the 80's.*Response & Proposed Measures in Closing the Gap*
- The migration of health professionals will not be controlled for as long as the causes why the Filipinos migrate continue to exist in the country. Primary focus should be in addressing the economic crisis and poverty affecting the majority of the Filipino people. This necessitates the concerted action of all sectors of the Philippine society.
- In the immediate, concerns like unemployment, low salaries, inadequate benefits, unfavorable working conditions must be improved. Education should be reoriented to produce graduates willing to serve the Filipino people. Health and education should be affordable and accessible to all Filipinos.
- The migration of health professionals must be stopped. At the policy level, pressures must be exerted to scrap the "labor export policy". Policies like wage freeze, freeze hiring, streamlining, cuts in social services, contractualization, privatization being implemented in accordance with globalization policies should be exposed and opposed. Meaningful programs like genuine land reform and nationalist industrialization should be implemented. These require political will from a truly pro-people government. Different groups and sectors must exert all efforts to push for structural changes both in economic and political spheres to carry out meaningful changes in the situation of the Filipino people.



# PNA 2011

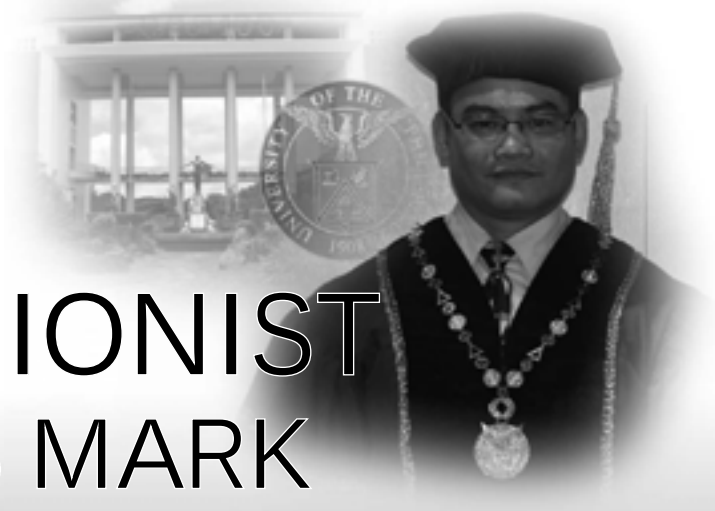
## NURSES WEEK ANNUAL





# CELEBRATION AND NATIONAL CONVENTION

ELEANOR M. NOLASCO, RN
Chair, Advocacy Committee, PNA



# NURSE-UNIONIST MAKES HIS MARK

A Nurse made history by becoming the first Staff Regent-elect to the University of the Philippines Board of Regents under UP's new charter. The UP Board of Regents, also known as *Lupon ng mga Rehente ng Unibersidad ng Pilipinas* is the highest governing body of the University composed of 12 members representing the various sectors in the University, the private sector, and the government.

On April 13, 2011, in a UP system-wide electoral exercise, some 9,000administrative personnel and research, extension, and professional staff (REPS) overwhelmingly voted for JOSSEL IBIT EBESATE, RN to be their official representative to the University of the Philippines Board of Regents. "Jossel" was then the National Executive Vice-President of the All UP Workers' Union (AUP-WU), "the sole and exclusive negotiating agent of all rank-and-file administrative personnel of UP" that endorsed and campaigned intensely for him leading to his landslide victory. He was also then the newly-elect National President of the Alliance of Health Workers, an organization of health workers in both public and private sector engaged in advocacy and promotion of health workers' rights and general welfare.

The position of Staff Regent was created in the UP Charter of 2008to broaden and further democratize representation of the various sectors in the UP community. Maybe it was fortuitous that Jossel won the April 2011 elections for Staff Regent considering that he was earlier a recipient of "Tsanselor 2008" Award given by the Chancellor of UP Manila to the 100 Outstanding Administrative Staff and UP personnel during the UP Centennial Celebrations in 2008.

With no pecuniary incentives nor privileges, the title however carries the immeasurable and distinct honor of having been chosen as representative of one's peers and fellow workers that comprise a sizeable number of the UP community. In the case of Jossel, a patent recognition of the selfless service he has discharged and the exemplary leadership he has demonstrated to uphold the best interests of the working sector he represented. In fact, more than his clinical competence as nurse, it was his dedication and sincerity as a union leader, unwavering commitment to pursue the struggle for "better wages, decent work conditions for health workers and free quality health care for the poor ," among other issues that built his credibility within the PGH community and the progressive health sector.

## Jossel, the Nurse and More

A Nurse VI plantilla eligible equivalent to Chief Nurse, Jossel has been in the nursing service for 24 years running. He entered PGH as Nurse 1assigned at the Post Anesthesia

Care Unit (PACU). In 5 years, he was promoted to Nurse IV or Manager of the Division of Nursing Research and Development (DNRD) eventually becoming the Division OIC and then landing his current assignment as rotating Chief Nurse in the Nursing Service.

In 1991, he was named Outstanding Staff Nurse by the PGH Nurses' Association in recognition of his important contribution thru nursing innovations at the Post Anesthesia Care Unit (PACU.

Interestingly, even as he was moving up the career ladder, the exciting part in Jossel's practice was not much about nursing but what was happening in-between. On top of the nursing roles he performed, more encompassing were the social responsibilities he chose to assume for his fellow health workers and the poor patients and hospital clients who were from the disadvantaged sectors. More than being a nurse, he considers himself a holistic health care provider who must not only treat the physical illness of the patient but equally address the social inequities and wealth disparities that cause disease.

## Linkages and Affiliations

His affiliations and linkages, past and present, show the breadth and depth of his total development as a change agent within the nursing profession but more substantially in the bigger society where health issues and concerns are subsumed by the socio-economic-political realities that impact people's quality of life. His greater involvement in people's health bespeak of his astute grasp of fundamental principles in the analysis and diagnosis of disease conditions beyond morbidity and mortality statistics and other health indices.

Among his various involvements in different capacities, we are citing some that we think significantly reflected his progressive (if not militant) stance and strong advocacies.

Global Health Workforce Alliance (GHWA),
*Geneva, Switzerland*
Representative of the All UP Workers Union Manila
International League of People's Struggles (ILPS),
*Utrecht, Netherlands*
Representative of the Alliance of Health Workers
International Migrants Alliance, Hongkong
Representative of the Alliance of Health Workers
LabourStart
*(An international internet portal on labor news and issues)* Philippine Correspondent (since 2008)
2011 Revision of the PGH Nursing Administrative Manual
Over-all Chairperson
League of PGH Head Nurses
Founding president,(1995*)*
A formation that continues to exert positive influence among its ranks and serves as a sounding board for policy-formulation in the nursing service.
*UP-PGH Health Forum (*1997-1998)
"A coalition of PGH/UP Manila employees, faculty and student organizations that successfully lobbied for the repeal/non passage of House Bill 7956 (Proposed Act Creating PGH as a Corporate Body - a.k.a. PGH Corporatization/Privatization Bill"
Network Opposed to Privatization (NO to Privatization), (1996-1998)
"A coalition of cause-oriented health organizations and individuals that opposed then plan of Ramos Administration to privatize major public hospitals in Metro Manila including the GOCC hospitals and PGH."
Coalition for Health Budget Increase, (2006-2010)
Acoalition of cause-oriented groups and public health workers unions that urged the national government to prioritize and allocate adequate budget for people's health and public health workers benefits, including PGH/UP Manila.
U.P. Kilos (2010-Present)
A coalition of UP employees, faculty and student organizations advocating for UP as a public national university and fully engaged in national development and people's issues; and promotion of good governance and human rights.

## Perpetual student in the School of life

Jossel hails from Aklan where he grew up in the small bucolic town of Kalibo. He earned his BS Nursing diploma with honors in 1986 from the St. Gabriel College where he taught briefly before joining the school's training hospital as a staff nurse. He simultaneously served as a volunteer community organizer at the Archbishop Gabriel M. Reyes Memorial Foundation. It didn't take long for the lure of big city practice to catch up with the young man. After two years of provincial practice, he moved to Manila and got admitted to PGH as staff nurse. At the country's premier training hospital, Jossel found a bigger arena to quench his search for knowledge. In no time, Jossel got caught in the vortex of local events and happenings that opened his mind to the politics of health in the context of social realities. Around the same time in late 80's, he enrolled in the masters nursing program of UP but this has always been relegated at the side because of other pressing social involvements. He even squeezed in some units at UST Faculty of Civil Law to gain legal perspectives pertinent to his social activities but dropped out eventually.

In his evolution as a union leader and a social activist, the hometown scholar has not lost his generally mild and staid

deportment. He has rarely given in to outbursts even at times of heated confrontations during union negotiations or political mobilizations and street rallies. Yet, he has been consistent with his convictions and beliefs, always firm with his stand and clear as for whom and for what his efforts were. And as he has established his ties where they are, winning hands-down the first electoral run for Staff Regent did not come as a surprise at all. The organizational machinery of the AUPWU made sure of that.

## The Private Jossel

Jossel is married to a non-nurse fellow employee who, like him, has spent long years of serviceat PGH. They have two sons of school age whom they are raising hands-on including bringing and picking them up from school alternately. This time however Jossel may just have to give up some of his domestic rolesto focus on the moredaunting responsibilityas Staff Regent; even as he must equally satisfy the demands of being Chief Nurse, national president of AHW, and a string of other social engagements all with serious implications. While trivial, the position of Staff Regent may take its toll too on Jossel as he has to shuttle to and fro PGH and UP Diliman where the Regent's office is. This is when his personal sport, mountaineering, would figure to provide the "precious" occasion for recovery, consolidation and revving anew the spirit. Such belief and passion for the sport made him found the UP-PGH Mountaineering Association in 2003 and now he sits as its acting president.

## INSIGHTS AND PERSPECTIVES

Jossel maintains a Facebook account where he often posts his musings on current events that sometimes start a forum among his friends and readers. We threw him some questions to elicit some "profound" answers relative to his rich experience as nurse-unionist. Below are excerpts:

*What was your process of "social awakening" like, so to speak?*

I grew up in a large family (with 11 siblings) and a political family. My father was "Teniente del Barrio" way back in the 60s and has held various other posts until the 90's in our province of Aklan. With this background, I've become grounded on the many social issues beseting our society. When I started in PGH (Manila) way back in 1987, it was the time of reorganization (and expansion work specifically the PGH Central Block Bldg). As a result, I was given the opportunity of attending (mainly on my own initiative) many fora and meetings on issues regarding the reorganization (both of UP Manila and of PGH) It was also then that some sectors in the hospital and the university wanted to eliminate the position of Assistant Director for Nursing (now renamed to Deputy Director for Nursing) and relegate once again this highest nursing position in the hospital to mere line manager (from an executive position). To recall, this issue about the position of ADN or DDN was almost a decade-old struggle of the nursing profession in the country that successfully culminated in 1986 when it was finally approved by the UP Board of Regent's. It then became the template position for head of nursing services in almost all government tertiary hospitals including those that were established later, namely, the GOCC hospitals in Quezon City (PHC, NKI, LCP, PCMC).

*How did your entry to PGH lead to your present social involvements and advocacies?*

Early in my professional life, as a unit representative of the PGH Nurses Association, I was given a chance to participate in what I would call a mass movement to promote the nurses' general welfare. From 1987 1988, PGH nurses, with the support of the UPCollege of Nursing and our professional organization, the PNA, rallied from the hospital to UP Diliman, tourge the University's Board of Regents to retain and put the position of ADN/DDN as deputy of the Medical Center Director in the proposed "five hospital," UP-PGH Medical Center. Eventually, the reorganization plan of PGH was disallowed by the Supreme Court in 1992 - for violation of security of tenure by then incumbent PGH Director.

Later, I participated in many activities of the Alliance of Health Workers (AHW) related to its campaign to protect the rights of health workers and the right to health of the Filipino people. Specifically, through the AHW-PGH Chapter that morphed into *the Unyon ng mga Manggagawang Pangkalusugan sa PGH* (UMAGAP-PGH), we spearheaded the first ever vigil/camp-out in the hospital in 1992, participated primarily by the hospital's utility workers and nursing attendants, to protest the unfair upgrading of said positions (UWs and NAs) under the Salary Standardization Law (SSL or RA 6758) in 1989. This protest action sparked a similar protest action in almost all hospitals under the DOH in the NCR. It was partially granted, when the DBM called for a general reclassification of government positions in 1993.
These colorful events early on in my practicehave led me to a life of advocacy having presented a social issue worth fighting for; an issue that "ticked" me as a person.

*What issues in PGH do you think reflect the country's health situation and what challenges do these pose?*

Being the biggest public hospital and a training hospital at that, PGH is both the base and the apex of the country's health care delivery system. Many health care concepts and practices were developed, applied, tested and evolved from here. People from all walks of life, go in and out of its portals either as administrator, employee, donor, health and human right advocate and of course, as patients. Given the profile of the latter, many of them indigents who come to PGH already in extreme desperation and in serious conditions, I think, they are a representation of the country's health situation.

The situation in PGH, in a way, is a microcosm of the state of health of our people where more than 80% of our patients are poor and more than 80% of those who come in do not have Philhealth coverage contrary to official claims started by the previous administration of an 80% coverage or enrolment nationwide.

PGH is underfunded by more than 100% resulting to perpetual shortage of hospital supplies including reagents for laboratory examination, drugs and medicines for charity patients.

More than 80% of hospital services, except the services of health professionals for charity patients, are no longer free, and now even Class D patients (the lowest classification of indigent patients) are being pushed to abide by a policy wherethe few remaining free services like x-ray will now have equivalent amounts to be charged to Philhealth (if you are a cardholder which many PGH patients are not) and/or use these as baseline for patient referrals to the University Physicians Medical Center-Faculty Medical Arts Building (UPMC-FMAB). The result: poor patients will have even less access to critical health care. And the one thing that stands against the implementation of this anti-poor policy is the strong opposition of the union - the All UP Workers Union.

Private interests, including some in-hospital diagnostic procedures and the UPMC-FMAB (private hospital within PGH) are getting headway inside PGH. Almost all administrators that come in and out of its portal believe that the government has no capability to maintain it without private business coming in for direct investment and converting the hospital into a profit source. In other words, with 80% practically classified as poor in our country (UNDP defines it as those who subsist on $2 per day), privatization is a real menace to public interest and public services.

Backlog of up to two months in many diagnostic and operative procedures of clinical departments on charity cases with long queues/too many patients.Even medical residents (if the patient's family agrees to pay) would suggest to just have a diagnostic procedure done at UPMC-FMAB even if the counterpart procedure is available in PGH ostensibly for fast and immediate result. Basically, a clear case of conflict of interest, considering that UPMC-FMAB is also primarily run (for profit) by PGH consultants/specialists who are also the immediate superiors of the medical residents.

There is a growing apathy (unless they themselves are involved or are victims) among health professionals on many social issues of inequity and disparity. Many still cling on to the hope of becoming an OFW or to be able to emigrate to a first world country eventually.

*What important lessons in organizing and leadership have you learned through the years of being an organizer and unionist?*

"*Mula sa masa tungo sa masa*" or from the masses to the masses. Power belongs to the people and emanates from them. For as long as your motivation is based on the issues of your constituency and you are genuinely one with them, your advocacy will be their advocacy and your leadership will be recognized and accepted.

*Can you share some insights on organizational strengthening and political leadership*?

Pertinent to the PNA, the fact that it is engaged in organizing and unifying its ranks, already makes it a quasi-political. And I think the only way for it to succeed in its efforts to organize and unify nurses for common objectives is to be responsive and relevant to the felt issues of its constituency. The PNA must also take up the people's right to health because they are the reason for our practice. The two issues of people's health and health workers' rightsshould make up for strong advocacies of the Association.

It cannot be unaffected to the many burning issues such as low pay of nurses especially those in the private sector. I think the PNA should be more aggressive with its organizing and assertive with its advocacies, both political actions I submit, but which experience and history have shown, as in our case, to be the indispensable tools for organization "success."

*"What we do within nursing field alone could be incalculable but not impossible. Let us do something that make a difference--- difference in something that make a difference--- difference in nursing itself, ordinary steps but 'different'. Breakthroughs in the sciences and in the arts. Something nice, something new, something fantastic, something true, something different yet familiar.*

*- Julita V. Sotejo*

CARMELITA C. DIVINAGRACIA, PHD, RN

CECILIA M. LAURENTE, PHD, RN

# *Thank you...*
# Dean Evangelina Maceda-Dumlao, *a genuine servant leader*

*Time finally came to an end to Dean Evangelina M. Dumlao, after a long, tireless journey in life. She could have done more especially on her charity works, but her physical body could only do so much. She was called Home for a lasting, eternal peace with her Creator on December l9, 2012, a week before Christmas. What a priceless gift accorded to an indefatigable, passionate, humble, self-sacrificing person* A *complete* lady, she touched the lives of people around her whether they know them or not, especially those in need. It is but important to know how she spent her life, professionally and personally, with humility and integrity.

She believed in life-long learning and practice it. Her parents wanted one of their daughters to be a nurse because of the humanitarian work of doctors and nurses, observed by her father who was employed at the Social work department , providing services to the poor. Out of obedience , she later took up nursing. After high school, she took up a secretarial course at the University of Sto. Tomas (UST) which she thought would be helpful to her in pursuing nursing. True to her promise to her parents, she enrolled at the Philippine General Hospital School of Nursing of the University of the Philippines (UP-PGH) . She was a brilliant student and graduated to become her batch's Honor awardee and a recipient of the Clinical Excellence Award upon her graduation from UP-PGH in l945 obtaining a title of GN (graduate Nurse). This title was changed upon passing the board examination for nurses and given a title of "Registered Nurse" which her parents were proud of.

Pursuant to her belief that education is a life long learning, she continued with her nursing career by advancing to the next level. She took up Post Basic course in Nursing at the Philippine Women's University graduating *summa cum laude*. In l956. Going up further, she enrolled at the University of the Sto. Tomas Graduate School, earning 2l units of master's degree program but continued to finish it at the Philippine Women's university earning the degree of Master of Arts in nursing, major in curriculum in l963. Continuing her academic journey, she obtained a fellowship grant from china Medical Board of New York and pursued a Post-master of Arts in Nursing degree, major in Maternal and child Nursing at the University of California in San Francisco. Advancing further her studies , she took up Postdoctoral Program in Education from the University of the Philippines, earning nine units.

She demonstrated excellence as a nurse and as a teacher. Her work experience as a nurse started at the U.P.- Philippine General hospital where she was a staff nurse, then a head nurse, then a private nurse between l945 and l953. It was reported that she was strict disciplinarian in her work. Her training was rigorous. She would remind her students that all of their patients be regularly sponged at the start of the day; their beddings well-mitered; their surroundings cleaned and beautifully arranged; their water container filled up, and that they were given enough water and food ,among others.. They must demonstrate appropriated caring gestures. She instilled in the minds of her students and nurses to always practice caring behaviours - to their patients and families and significant others.

The beginnings of her teaching career were between l954 and l960 when she became a nurse instructor and then a supervising nurse instructor taking charge of staff development at the Veterans Memorial Medical Center, Then in November 2, l960, she was invited to join the University of East Ramon Magsaysay Memorial Medical Center College of Nursing (UERMMC-CN). It was Dean Purita Asperilla who invited her to join the faculty of the College. She became instructor in Pediatric nursing, an area where she loved most. She put her Maternal and Child nursing education to work from l964 to l968. With her outstanding performance, not only in teaching but also on administrative matters, she was promoted to Assistant Professor then Assistant Dean of the College from l968 .

After the retirement of Dean Asperilla in ,she accepted the challenge to assume of the dual of the Dean of the College and Chief Nurse of the UERMMC Hospital until her retirement in l97l. She proved that education and service did improved teaching to students and nursing care to patients. But after relinquishing her dual positions as Dean and Chief nurse at UERMMC. She was appointed Hospital Administrator from l984 to l988 and continued to assume her professorship at the College, teaching Management and Leadership in nursing to senior students It was her policy in her course on leadership that all students shall go on duty during holidays, such as during Christmas and All Souls Day when few staff is around. Her reason was for them to experience how it was to be away from their loved ones and be with their patients. Students must learn and feel to self-sacrifice for the sake of their patients who would might be suffering from pain and loneliness and needed someone to care for them. Students' presence during holidays is enough for them to feel good and have peace of mind. To Dean Dumlao, this is caring- --sharing ones time during holidays not only with patients but also with hospital staff as part of their academic-service partnership work.

Retired but not tired: continued to render service and charity work. Dean Dumlao's reach went beyond the nursing community and the academe extending to socio-civic organizations, such as the Zonta Club of Manila of which she was the treasurer ,and chairman of the Scholarship committee, Buklod ng Pag-ibig Catholic Charismatic Community of which she was the chairperson of the Executive Council, the Foundation for the Elderly of which she was the president of the Membership committee among others. Her generosity extended to numerous charity works. She was said to have a generous personhood--unselfish and big-hearted especially to the needy. Recognizing that there were poor but academic deserving students, she established a Scholarship program in her name providing financial support in terms of tuition fees and other minor expenses. Now, they are practicing their profession. Thanks to Dean Dumlao.

For years before her ailment, she used to help older persons at the Golden Acres, feeding them. She would cook "lugao", bring food to Golden Acres and feed the older persons. Feeding , talking and praying with them were some of the things she would do to perk them up or to energize them. She knew that these patients live away from their loved ones , thus feeling lonelyand empty. Her physical presence might help in filling up their emptiness and loneliness.

Host of Awards She received numerous award including Outstanding Professional in Nursing from Professional Regulation Commission in l99l, Humanitarian Award from UERRMMC Nursing Alumni East Coast Chapter USA in l995, Outstanding Service Award from the Nutrition foundation of the Philippines, Professional Award by UPCN Alumni Association in l983 Community service Award by the Rotary Club of Antipolo, Outstanding Service Award by the Inner Wheels Club of the Philippines in l984, Anastacia Tupas Award for nursing education by Philippine Nurses Association in l990.

But her lifetime fitting tribute to a distinguished person would comprise the following:

First, the Title of Dean emeritus was conferred on Dean Evangelina M. Dumlao in l998 in recognition of her:

- Outstanding achievements as Dean of the UE College of Nursing laying down the foundations which made the school what it is todaya center of excellence in nursing education;

- Distinguished service to the UERM Memorial Hospital as Chief nurse and Hospital Administrator making it a place of outstandingcompetent and caring nursing leader.

This was conferred to her in l998 by the Academic Council and the Board of Trustees of UERMMC in l998 manifesting their appreciation and gratitude of Dean Dumlao for long-dedicated and distinguished service to the Institution .

*turn to page 36*

# KEY-BOOSTER SYSTEM: A THEORY IN CLINICAL NURSING FOR THE TERMINALLY-ILL

CECILIA M. LAURENTE, PHD, RN

Death is a fact of human existence. Indeed, dying is a normal, healthy process. It is not an enemy to be swatted at and parried to the last grim moment.

However, some of us still regard death and dying as an undue condition of life, that there seems to be little or no scientific understanding of its significance. While we recognize that death is inevitable and universal, we cannot imagine our own death. If ever there is talk about death, this is usually done in a humorous fashion. Our reluctance to talk seriously about death can be explained partially by our sensitivity, sympathy and compassion for our fellowmen and for ourselves.

Take the case of patients with terminal illness. Undoubtedly, they need utmost comfort and care. These patients seem to say, "There is nothing more I can do." There may be no further surgery, drug therapy or treatment, but that is still not the end of the line.

There remains the relationship between patients and those around them. As often observed, however, some people, nurses included, resist personal involvement with the terminally-ill. This is probably because they feel very uncomfortable with the concept of death and dying. Whenever they are aware that a patient is dying, they have a hard time facing the fact and acknowledging it. They then use different coping mechanisms, with behavior, rituals and personal communication styles, to the detriment of an effective person-to-person relationship. As a result, patients feel neglected and nurses may build negative feelings toward them which then lead to impaired self-esteem. The patients may then pass away with more difficulty than they expected.

Since nurses have more contact with the dying patient than any other group of health/hospital professionals, their responses to patient behavior are quite important in determining the context of dying. While it is still the doctor who decides on the patient's medical care and who has the most knowledge about one's condition, it is the nurse who performs the caring duties.

It is therefore the purpose of this paper to present a theory on how nurses can meaningfully contribute to the enrichment of the quality of life of patients with terminal illness. Thus, as he or she accompanies patients on their journeys on earth, that they may face death peacefully when it comes.

## Theoretical Background

Weisman, in Donovan (l976), *identifies three (3) stages that the terminally-ill encounter over time.* Stage l occurs from the time the patient begins to notice some stressful signs and symptoms until the diagnosis is established. At this time, efforts to protect the status quo by denial, rationalization, and reassurance-seeking are evident. Stage 2 covers the time between diagnosis and the point of final decline. Glaser and Straus (1965) claim that the reactions to the impending death begin when certainty is seen. They identified four types of "awareness contexts": Closed Suspicion, Mutual Pretense, and Open.

In the "closed" context, the patient is not aware of one's terminal condition, even though the nurse and patient's family may be. The nurse tries to keep the patient from becoming suspicious and encourages him/her to make his/her own

interpretations regarding his/her condition. This is so even if one's interpretations are falsely optimistic. This usually occurs in the early stage of a serious illness.

In the "suspicion" awareness context, the patient suspects that he/she is dying, but all his/her attempts to confirm this, by consulting the nurse, are rejected. This may develop when a patient is transferred to an intensive care unit, when treatment procedures hint at a terminal illness or when the nurse is not careful in concealing knowledge of probable imminent death from the patient. The nurse ignores patient's questions about his/her condition and engages in somewhat trivial conversations with him/her.

The "mutual pretense" context occurs when both the nurse and the patient are aware of the terminal nature of the illness but agree, implicitly or explicitly, to refrain from discussing it. This gives the patient some comfort because some staff members do not tend to avoid him/her. If either party decides to discontinue the pretense, the situation may become one of "open" awareness.

In "open" awareness, there is free discussion of the experience of dying and of plans for the dying patient's responsibilities. In t context, the patient can control some of the aspects of his/her dying, e.g. persons present at his/her deathbed, place of dying, dress to be worn and other specific plans.

According to Kubler-Ross (1971), patients, in general, should be told of their illness even at the terminal stage. But not all patients would like to be told. If they feel weaker everyday, it may be interpreted as being in a "hopeless" situation. Also when the nurse and significant others are slowly withdrawing from the patient, they may interpret it as their hopelessness to pursue treatment and extend caring environment as in boosting their (patient's) inner energy to restore "hope" and/or "self control".

Having allowed for confrontation with the inevitability of death, the patient faces conflicts in four areas:

1. impaired self-esteem
2. feelings of endangerment (fear of pain)
3. fear of annihilation (fear of cessation of self)
4. fear of alienation (fear of losing relationships with others)

The dying person reacts to these four basic fears in both Stage 2 and Stage 3, the stage of final decline. However, the threat to self-esteem appears to be the most basic. A person who feels worthless rather than worthwhile has greater fears of endangerment, annihilation and alienation.

Cappon (1959, p.3) posits that as illness progresses or becoming more severe, nurses become less visible: less touch, less talk, less caring gestures. However, according to Lamerton (1972, p. 1545), "There is a tendency once a patient has been earmarked as incurable, to forget him, to withdraw quietly and leave him alone." In a research conducted by Quint, in Shusterman (1973) on the attitude of nurses toward death, it showed that it is often difficult for the nurse to know how to respond to the patient because he/she usually lacks first-hand information about what the doctor has told the patient about his/her condition. And even when the nurse knows a patient is dying, it is unlikely that he/she will tell the patient's true prognosis. In fact, the barriers to verbal interaction between nurses and patients increased as the extent of illness increased. Furthermore, the sense of desolation and loneliness to which this often gives rise to can be dreadful. One may exhibit resentment and aggression, or just an overwhelming hopelessness.

On the other hand, Fromm, in Glaser and Strauss (l965), has identified three (3) behavioral responses to the shattering of hopes:

1. Some persons resign themselves to fate. They have an average optimism and hope for the best but then lose their capacity to dream;
2. Some people who lose hope isolate themselves from others, withdrawing in order to avoid being hurt by more unfulfilled hopes; and
3. A result of shattered hope may be destructiveness against self because that drive is no longer subordinated to other goals.

For more individuals, the "will to live" is part of the experience of being seriously ill. Authors and investigators emphasize the importance of maintaining hope in the patient, the assumption being that hope aids the patient in resisting death or minimizing symptoms. Studies have shown that more depressed and less hopeful patients are more likely to die from a serious illness than those in more optimistic frames of mind.

Appraising the patient's situation to find the roots of hopelessness is important. The major nursing intervention for hopelessness is the attempt to motivate. Both the patient and nurse must be realistic regarding the severity of the situation but someone must provide the strength to see positive alternatives and to move ahead. There must be someone to emphasize what strengths the patient has and not one's weaknesses. Another intervention is to provide goals that increase from simple to complex. The staff may thus help patients see progress more easily. Listening to and caring for the patient as an individual are basic ingredients in generating hope.

Seligman's theory of helplessness extends from a reinforcement paradigm; specifically, an operant conditioning model. This theory predicts that "situations in which the individual's voluntary actions have no effect result in learned helplessness. Consequences of learned helplessness are that the person becomes motivationally and emotionally deficit" (Lewis, 1982, p.115)

To varying degrees, the individual with terminal illness believes that either one can or cannot affect one's situation, that either outcome is a result of one's own behavior or a result of forces beyond one's own control. According to Lewis (l982), "If patients, through a history of non-control, come to believe that what they do does not matter and that it will not affect their situation, they see themselves as having no control. They can suffer anxiety, a diminished sense of purpose in life, and feelings of lower self-esteem." Reinforcement of the control over life might then positively affect the patient's self-esteem and chance to experience meaningfulness in life. For patients, relinquishing control increases hopelessness. The critically ill, for instance, may feel powerless. One may not be able to monitor one's own bodily functions or control intrusions into one's environment. One needs to be reassured that the work of worrying about mechanical supports and monitors is given temporarily to nurses who can manage life-support systems competently. The nurse can control interruptions in patient's rest and privacy to maintain one's energy, comfort and psychological and physical integrity.

Kratz (l986) says that a lack of energy promotes powerlessness. Energy comes from physical sources (e.g. calories, oxygen), rest and motivation. It is used for growth and mobility, and in the chronically-ill, for coping with the effects of illness. He suggests that "meditation (prayerful or otherwise), routine progressive relaxation, creative imagery and autogenic suggestion" can be used by nurses to overcome powerlessness" (p. 4).

Much of the work of nurses concerned with terminal illness is to prevent anything to arise which may hinder growth (e.g. tolerance and courage) in the patient's being. The patient must be free from pain, but still alert. The patient must be told as much of the truth about one's condition as one can cope with. The patient must be encouraged to turn one's attention away from oneself, and must be shown a clean example of real service.

According to Donovan (l976), each individual has certain strengths which can be drawn upon even during the process of dying. Emphasis is often placed on losses, weaknesses, and deficits to the exclusion of inherent strengths and resources. For instance, the patient may be faced by such problems as a rejecting family, a bleak Christmas, a negative outlook, and difficult or uncontrollable asymptomatology, but the patient's religious beliefs may be a potential source of strength and consolation.

## Theory Presentation

The following concepts have been used in the development of the Theory of Key-Booster System:

Man is a multidimensional (bio-psychosocial) human being capable of developing one's own resources to preserve one's "wholeness." However, at some point, one may need "external stimulants" or "boosters" from without for one to realize one's self-worth and self-esteem.

Nursing is the process of assisting the person generates one's (the patient's) inner resources and strengths for one to realize self-worth and self-esteem thus enabling one to face death peacefully.

The nurse is the significant professional partner of the patient with the following personal attributes: patient, understanding, efficient, competent, full of energy, dedicated and committed to the care of the terminally-ill. The nurse extends nursing care with competence and compassion, and is not afraid to sow the seeds of hope and to accompany the patient in one's journey in life until one's final hour with one's terminal condition.

## Assumptions

l. The patient knows of one's terminal illness and believes that no one knows the prognosis in time, even in the absolute or mathematical sense;
2. All individuals are unique and have their own constellation of psychological, sociological and personality characteristics that produce behavior;
3. The nurse is a very significant member of the patient's environment in the hospital, as a chief source of boosters of energy especially for patients with terminal illness.

## Definition of terms

1. Terminally-ill - a state of being when there is no further medical treatment that can stabilize a patient; a declining condition for an extended period time.
2. Impaired self-esteem - a condition when a person feels dispirited, worthless and endangered. One may have fears of e.g. annihilation and alienation and may exhibit either or all of the following behaviors: hopelessness, helplessness, and powerlessness.
3. Hopelessness a person's response to impaired self-esteem, because of terminal illness, when one has given up hope and exerts no attempt to overcome the threatening situation with a feeling that one is "at the end of the rope." The person manifests a combination of the following:
   - hypoactivation (patient feels "empty," or has difficulty identifying feelings precisely),
   - emotional distance
   - general psychological discomfort (sense of loss and deprivation, irritability, tenseness or feeling a "lump in the throat")
   - social withdrawal; a sense of incompetence (expression of vulnerability, feeling unable to accomplish anything, or feeling overwhelmed by life)
4. Helplessness - a person's response to impaired self-esteem related to terminal illness when one has decreased one's attempt to overcome the threatening

situation and allows whatever is about to happen to occur. However, one still holds on to hope which manifests in a combination of the following:

- a sad and dejected appearance (but may have a cover-up of gaiety)
- talks very little or not at all
- complains of disrupted sleep patterns
- being unable to sleep at night
- anorexia (but may have a cover-up of overeating)
- constipation

5. Powerlessness - a person's response to impaired self-esteem related to terminal illness, when one feels that one has lost personal control, or has lost a sense of mastery of oneself. The person manifests a combination of the following;
   - as in helplessness
   - regression to an "immature" level of self-centeredness
   - psychosomatic complaints
6. Hope Booster System is a mechanism of instituting a set of strategies/activities by the nurse to help the "hopeless" person draw on personal resources and strengths to restore a realistic hope in him/her.
7. Hope is the expected outcome when the person is subjected to the Hope Booster System by the nurse. One does not only hope for a cure and a return to the "best person possible today", but also does not let a moment escape without appreciating its richness. One's hopes may change from "hoping it's nothing serious," then "hoping for treatment," then "hoping that if I'm not accepted in this garden, I hope I'll be accepted in the next garden."
8. Self-care Booster System - is a mechanism of instituting a set of strategies or activities by the nurse to help the "helpless" person draw on personal resources and strengths to restore self-care/reliance in him or herself.
9. Self-care - is the expected outcome when the person is subjected to the self-care booster system as encouraged by the nurse. One practices activities that one initiates personally. One performs these activities (e.g. daily living) to maintain life, health, and wellbeing within one's limitations.
10. Power-booster system - is a mechanism of instituting a set of strategies/activities by the nurse to help the "powerless" person draw on personal resources and strengths to restore personal control.
11. Personal Control - is the expected outcome when the person is subjected to the power-booster system by the nurse. One is able to make decisions, monitor own bodily functions and control the intrusions into one's environment.
12. Boosted self- esteem - a state where a person feels "worthwhile," respected and valued. Manifestations of hope, self-care and personal control are evident.
13. Peaceful death a state of a person with terminal illness (or a dying person) when one is able to maintain inner growth in the presence of a continuing physical decline; being happy, calm and in control of the situation; prayerful; comfortable and at ease, claims that one is ready "to go" happily and in peace.

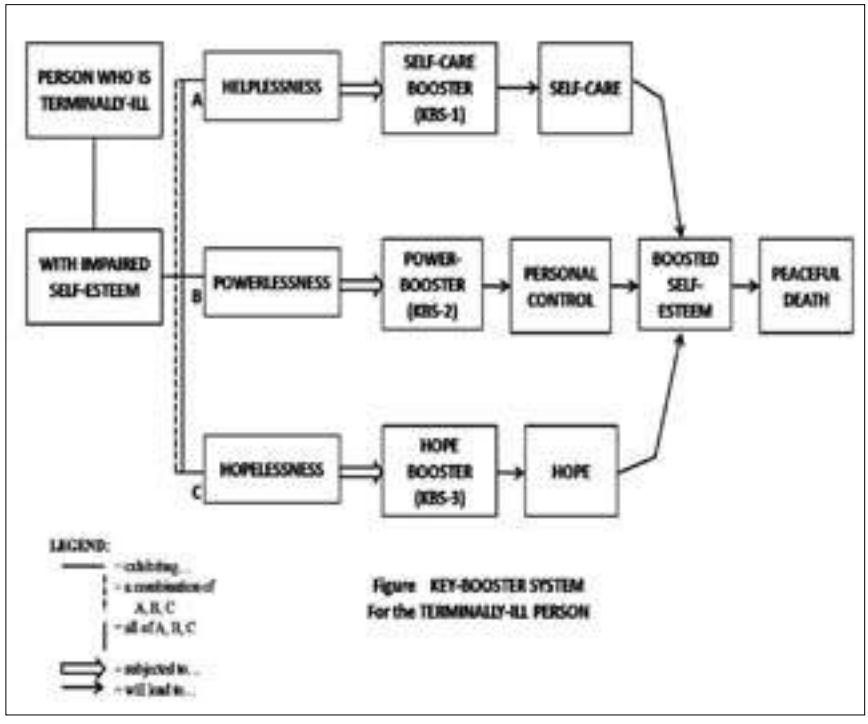



Figure 1 illustrates the operationalization of Key-booster Systems for the Terminally-Ill that guides the nurse in his/her care of the patient. This shows how the terminally-ill with impaired self-esteem is subjected to "repair work" by the nurse to reverse the patient's response toward a desirable outcome. Once "self-care," "personal control," and "hope "are attained, the patient's "self-esteem" is likewise boosted. It is, however, difficult to say up to when the Key-booster system should be done by the nurse. Time is not a question of duration anymore, but a question of depth and meaningfulness. Once the person feels and believes that he/she is loved, needed, valued and worthy (boosted self-esteem), he/she can happily say, "I'm ready to go to."

## Brief Explanation of the Theory

A person who is terminally-ill may know that death is inevitable through "mutual pretense" context or "open awareness" context. One then tries to plan for one's final hour. But somehow, along the way, as the physical body deteriorates and one's symptomatology becomes difficult to control, one can sense saneness drifting away. Consider a combination of

or all of the following situations which confront the patient:

- the failure of one's loved ones to visit as desired (probably because of distance and/or financial difficulty, etc.);
- the failure to preserve the beauty of one's body (probably due to alopecia, sore lips, extreme emaciation, etc.);
- the presence of foul odors emitted from body discharges/secretions;
- the occurrence of excruciating pain or discomfort which hinders one to perform activities in daily living;
- impaired vision and/or hearing; and
- progressive development of body weakness.

With the impairment of self-esteem, reactions may either be feelings of helplessness, powerlessness or hopelessness or a combination of these emotions. Unless no attempt has been made to "repair" the impaired self-esteem, the probability that the patient will have a peaceful death is nil. One will die in agony with a feeling that one is not ready "to go."

In the hospital setting, the nurse is a constant and important figure in the environment of the patient. The nurse's goal is not of "curing" the patient, but of caring, making a patient comfortable and at ease. Since a cure is not the goal, death, therefore, is not a defeat. The main concern, then, is how to help the patient face death peacefullyfull of inner joy, contentment and hope, so that one will be "accepted in the next garden." The nurse holds the "key" that opens the patient's door, mobilizing one's inner resources and strengths, and inspiring him/her. The right key, if used properly and gently, will turn HELPLESSNESS TO SELF-CARE, POWERLESSNESS TO PERSONAL CONTROL, and HOPELESSNESS TO HOPE. The *key*- booster SYSTEM (KBS) is a mechanism employed by the nurse to boost the self-esteem of the patient, which is an important ingredient to enable one to face death peacefully.

## References


Cappon, D. "The dying Patient", *Psychiatric Quarterly*. *XXX111-3*, l959

Donovan, M. I. (1976). *Cancer Care Nursing*. New York: Appleton-Century-Crofts, USA

Glaser, B.G. and Strauss, A.L. (1965). *Awareness of Dying*. Chicago: Aldine Publishing Co., USA

Kratz, C. "The healing Touch". *Community Outlook* (January, l986), p. 4.

Lamerton, R. "Care of the Dying". *Nursing Times*. LXVIII-49 (December 7, l972), pp 1544-1545.

Kubler-Ross, Elizabeth. "What Is It To Be Dying?" *American Journal of Nursing. LXX-I* (January, 1971), pp.54-61.

Lamerton, R. "Teamwork". *Nursing Times*. *LXVIII-52* (December 28, l972), pp. 1642-1643.

Lamerton, R. "Care of the dying the right time to die*". Nursing Times LXVII-8* December l4, l972) p. 1578.

Lewis, F.M. "Experienced Personal Control and Quality of Life in Later-stage Cancer Patients". *Nursing Researcn.XXX I-2* (March/April, l982), pp 113-119.

Shusterman, L. "Death and dying". *Nursing Outlook. XXI-7* (July, l973), pp 465-471.


*Thank You... from page 31*

Second, is the establishment of the Dean Evangelina Maceda-Dumlao Lecture Series on Nursing Leadership in recognition of her distinguished nursing leadership. This undertaking would provide more venues for scientific inquiry to build knowledge in order to improve the quality of life of the Filipinos. Also, it will help the Medical Center in achieving its dream to become a premier academic Medical Center the BEST among its peers. This was launched in 2007. Since then six lectures were delivered by distinguished speakers on the following topics:

- February 9, 2007 - "Reflections on Nursing Potpourri" with Dr, Amelia M. Maglacas as speaker;
- December 8, 2008 "Care Quotient: A Measurement of Caring" by Sr. Carolina Agravante, SPC;
- February 4, 2009- "Compassionate and Ethical Leadership" by Ma. Eugenia Dumlao-Reedy;
- March l0, 20l0- "Technological Competency as Caring in Nursing: Implication for Research and Practice in Nursing" by Rozzano C. Locsin;
- January 27,20ll- "The Puzzle of Pain" by Susan Fowler- Kerry;
- February 3, 20l2- " Leading and engaging the Global Nursing Workforce" by Reynal R. Rivera.

The Dean Evangelina Dumlao lecture series will be annually delivered not only to perpetuate her name but also to influence the minds of the Philippine nursing leaders and practitioners in shaping the future of nursing not only in the Philippines but globally. Trul , her offering of herself was for the greater glory of God, she would often say.

What matters most to her were not merely the awards bestowed on her by various prestigious institutions and organizations but her offering of herself her time, resources, her teachings to people around her especially the needy. She had almost everything but she shared them with others. She had accumulated knowledge and learnings but shared them with her students and colleagues. What matters most is not her competence but her character.

Now that she is gone, she will be truly remembered not for how long, but by whom and for what.

To Dean Dumlao, our deepest gratitude for touching our lives.

DAN ERWIN C. BAGAPORO
*College of Nursing*
*University of Santo Tomas*

# PRIDE IN PROFESSION

*I am Dan Erwin C. Bagaporo, a 21-year-old native of Malabon City and currently a 4th year Nursing student at the University of Santo Tomas College of Nursing. I'm a regular college student who loves sports, writing, music and most of all, fun. I'll be graduating this March and am looking forward to passing the Nursing Licensure Examination and joining the wonderful field of healthcare.*

*The Competition*

*My essay won the 2011 Goi Peace Foundation - UNESCO International Essay Contest for Young People. The contest is an annual event sponsored by the Goi Peace Foundation based in Japan and the UNESCO. Last year, its theme was "My Story of Inspiration". It attracted 6,932 entries from over 140 countries. It has two categories: Youth's and Children's. The first prize winners (myself and Aurora Sarker, a 14-year-old girl from Bangladesh) were invited to attend the Goi Peace Foundation Forum 2011 last November in Tokyo, Japan. There, we recited our winning pieces in front of ambassadors and delegates from different countries. We also listened to the talks of visionaries like Bill Strickland, CEO of Manchester Bidwell Corporation. The event also included tours of different sites in Tokyo, as well as a local high school where we were given the chance to share our culture with Japanese students through a presentation.*

*The Article*

*I wrote "Pride in Profession" last June 2011. It was a few weeks after I had helped some of my friends with the data gathering for their thesis. Their topic was "geriatric loneliness", and this led us to one secluded retirement home.*

*The scene in the home was peaceful, but you can sense a kind of gloominess around the surroundings. The people kept themselves busy with yard work, praying, talking and of course, the always transcendent Filipino favorite activity, gossiping.*

*During that day, I documented situations and stories that really struck me. If you read my essay, you can see one of these stories in it. The reason for this is because I want to introduce a new concept of Nursing to people. I think we can both agree that for the past few years, the wonderful image of Nursing has been overshadowed by unemployment, seemingly limited opportunities and other negative connotations. I wanted to change this, and one way I saw how was to show the interaction of 3 concepts: Caring, Career Diversification, and Opportunity.*

*I think Nurses are very versatile. We can specialize and become a staff nurse, OR nurse, community health nurse, epidemiologist, or researcher. But whatever our specialization may be, the common thing we do is that we*

*care for people. With this, I pointed out that one effective way to care is through research. My friends' study about geriatric loneliness is an example of how research can help describe a problem so that others can see and do something about it. Just by our ideas, we are able to help society attain optimum function, similar to patient care.*

*This is not just seen in research. There are many other areas where nurses can choose to implement change. Through my essay, I want everyone to know that no matter who we are or what our profession is, we can make a difference, if we choose to. This is my vision and I want to share it with those who doubt themselves or their abilities. I want them to become empowered so that we can all work together to create a better world.*

*Again, thank you so much for this honor of giving me the opportunity to share my perspectives.*

*This is my "Pride in Profession".*

. . . . . .

## Pride in Profession

Being a nursing student in the Philippines is very hard. You have to deal with the thought that, after graduation, you will be among thousands of others competing for limited employment opportunities. Many nursing graduates end up un- or underemployed. Sadly, this has led to stigmatization. Every time people ask me what my course is, I would say Nursing and they would shake their heads.

Many are starting to poke fun at my profession. At one point, I heard my friends joking around, “You'll train for four years and then what? Wash bed pans?” I have to admit that this stigma got to me. I saw myself as someone insignificant. I came to school uninspired and did not bother exerting much effort in school work. “After all, you're just a nursing student,” they told me.

It was not until the summer of my third year that I found inspiration in the most unusual place. Last April, some of my friends invited me over to help them with their thesis. My friends' study was about geriatric loneliness. They asked me to help them by distributing questionnaires in this secluded compound surrounded by tall fences. It was very peaceful and quiet, but not well-maintained. The corridors had a pungent smell and the comfort rooms were in a deplorable condition. The facilitators were doing their best to maintain the facility, but were clearly understaffed and lacked in funding.

During the interviews, I got to know the stories of the people who lived inside this compound. Most of them were either abandoned by their families there or were rescued from the streets. I remember one homeless woman who was “taken” from the streets by the authorities, separating her from her family who were not with her at the time. She was then brought to the retirement home. Because of this, she never saw her family again. She went on, describing her condition and her experiences. It turned out that she had been suffering from hypertension and arthritis for some time now, but can hardly manage it because of a lack in consistent medical supervision or advice. She never asked me if there was a way that I could reunite her with her family.

To be honest, I did not know how to react. I wanted to help reunite her and her family, but it was just not possible, given the limited resources. So, I just remained silent and listened to her. After a while, I gave her some health advice regarding the home management of hypertension and pain, like eating raw garlic and putting a warm compress on affected areas. That was all I could do, I guess, being just a nursing student. We then continued our conservation. I sensed that her mood was growing lighter, because we were already exchanging a few laughs. Before the interview ended, she asked me again for my name and course. “Dan,and I'm taking up Nursing,” I said. That was the time when she said the words that I still keep in my heart up to this day: “Thank you, Dan. I'll pray for you. I'll pray that you will finish your course.” After this, I tried to listen and give as much health instruction as I could to the other people I interviewed. It was during this day that I realized the importance of who I am and what I'm doing. I was not just simply doing interviews, I was actually caring.

Nurses are trained to care and I realized that listening to patients and giving health advice are expressions of caring. I began to see my profession in a new light. I realized that the most important question to be answered is not “How will you fare after you graduate?” Rather, it is “How many people can you help at the end of the day?” This experience has made a difference in a person's life. All you need is a listening ear, empathy and basic practical knowledge.

After that summer, I began to exert more effort in school work and in joining organizations. I became active in our Red Cross unit and started joining medical missions. I even plan to specialize in research and geriatrics upon graduation. One day I also plan to go back to that retirement home, make another study or at least, do something to make the lives of the people there better. I want to pay them back, because their stories gave me the strength and determination to continue my own journey. No, I am not just a nursing student. I am a nursing student. And no one will ever take away the pride in that statement from me again.

TITA RILLORTA, *RN, MSN*
*Faculty*
*Our Lady of the Pillar College-Cauayan*

# ALTERNATIVE MEDICINE: Training At The China Beijing International Acupuncture Training Center

I took an Advanced Acupuncture Course at this institution last August 7- November 4, 2011. My expectation was that I would be able to update the knowledge and skills in acupuncture that I've acquired a long time ago when I was still a full-time CBHP worker. I salute my first trainer, a Japanese acupuncturist who came to the Diocese of Ilagan. The theories and principles I learned from her were quite similar with that of Traditional Chinese Medicine (TCM).

The Advanced Acupuncture Course curriculum included moxibustion, massage, cupping, qigong, and herbal medicine. I was amazed at how the Chinese were able to preserve the traditional methods of treating diseases as well as promoting health, inspite of their advanced western health technologies.

In our clinical practice, much of our time was spent watching the doctor's technique because we were only allowed to insert a needle occassionally. During these observations, I was very impressed with the patients' attitude towards TCM. After their acupuncture treatment, every patient would want the doctor to perform cupping on their back. Some patients would even request for bleeding! Chinese people love cupping so much. This is manifested by the "hematoma" marks numbering around 6-10 pairs and as big as a glass mouth on their backs. When I saw this, I felt uncomfortable because this might not have been acceptable in our country.

*Bleeding therapy to improve circulation and to relieve pain and discomfort in extremities*

*An eleven-year-old ADL patient*

*Cupping after acupuncture treatment*

Bleeding, moxibustion, qigong, hot packs using herbs and other forms of traditional treatment are very common and acceptable among Chinese people. These are also common practices of our traditional healers in the Philippines but our weakness is that we nurses are not interested in propagating or accommodating these traditional beliefs and practices even if these may be beneficial to our health. Instead, we are easily convinced by advertisements distributed by multinational

*turn to page 41*

# Letter to the Editor

Christmas 2011

*Dear Editor, PNA Journal of Nursing,*

*Peace and bountiful goodness. I have been wanting to Thank You for the 2 Philippine of Journal of Nursing Jan-December 2010 issues. This must be your way of tracking PNA Life Members! Yes, I am still alive and active, being assistant nurse of our FMM Prov. Inf. Here in GMA, Cavite, with more than 20 sisters sick, old, retired of various multiple ailments. We have 3 nurses (2 FMM sisters and 1 Prof. RN) and 7 Carers . This is like a small hospital as the carers go on an 8-houir shift. The other sisters and I are on call 24 hours a day. At 75 years, wearing hearing aid on both on both ears with HPN, I would say I am still able to function. Previous to this I had been managing three clinics for the poor- training voluntary community health workers with the use of herbal medicine, therapeutic massage and acupuncture.I am quite proud to say, the Volunteer Community Health workers (VCHWs) are not PHITACH Certified Associate Acupuncturists a first in the Philippines. They are not even High School Graduate for various reasons.*

*I might visit the office as I want to replace my old faded life membership card and I ask if there are nearby PNA Chapters I can affiliate myself. Thanks again and hope to receive future PNA journals*

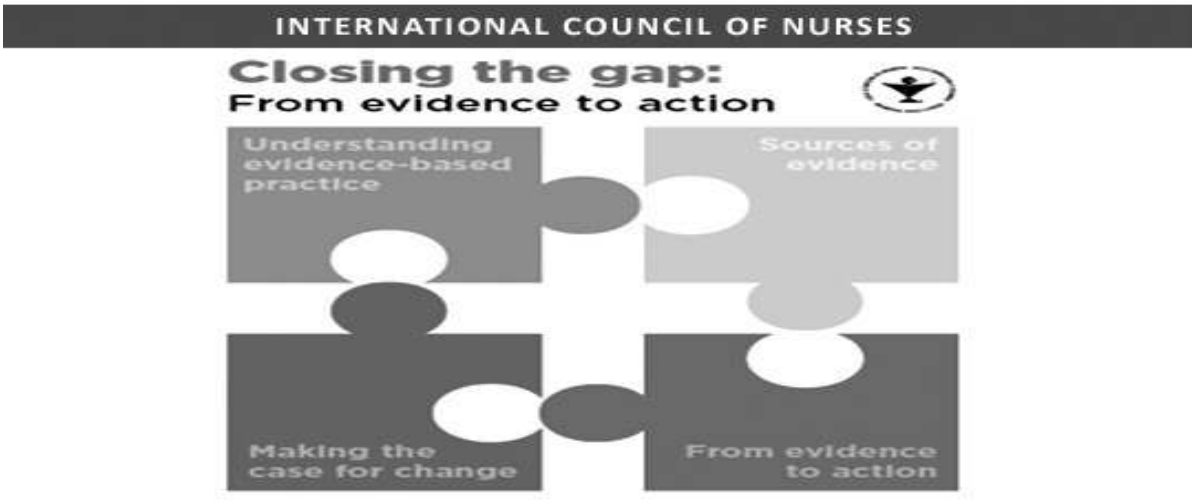
*Affectionately in Christ,*

Gloria M. Coquia, FMM, RN
St Joseph convent FMM
Tahanan Compound
411-F GMA Cavite

# Announcement



This year's theme for the
**International Nurses Day Celebration** on May 12, 2012:




*Alternative Medicine... from page 39*

corporations who produce health products of any kind. A majority among us nurses stand by the belief that "everything made in the west are the best," forgetting traditional modes of treatment.

To give only some examples, there are some nurses who prefer to promote slimming pills rather than to educate people about a healthy lifestyle that includes proper diet and physical exercises. Western drugs are the first choice for skin diseases and dandruff instead of acapulko leaves because of the time-consuming preparation process. What is more, we forget the potential longterm effects of western drugs to our livers and kidneys!

As a community health nurse my recent exposure on Traditional Chinese Medicne reinforced and strengthened my advocacy in the use of alternative medicine. As an effective alternative, it is financially and culturaly sensitive and accessible to the basic masses.

## A Nurse's Prayer

*O my God, teach me to receive*
*the sick in your Name.*

*Give to my efforts success*
*for the glory of your holy Name,*

*Grant that the sick you have placed in my care*
*may be abundantly blessed, and not one of them*
*be lost because of any neglect on my part.*
*Help me to overcome every temporal weakness,*
*and strengthen in me whatever may enable me*
*to bring joy to the lives of those I serve.*
*Give to my eyes light to see those in need . . .*
*my heart compassion and understanding,*
*my mind knowledge and wisdom,*
*my hands skill and tenderness,*
*my ears the ability to listen,*
*my lips words of comfort,*
*my spirit the desire to share.*
*Give me grace, for the sake of your sick ones*
*and of those lives that will be influenced by them.*
*It is your work--*
*Without You, O Lord, I cannot succeed.*

*Amen.*

# PHILIPPINE NURSES ASSOCIATION, INC.
## (PAMBANSANG SAMAHAN NG MGA NARS NG PILIPINAS, INC)

## BOARD OF GOVERNORS 2012

**Mr. Neil M. Martin**
*Chairperson*
*Governor, Region X*

**Ms. Flordeliza R. Bobiles**
*Corporate Secretary*
*Governor, Region I*

**Mr. Noel C. Cadete**
*National President*
*Governor, Region VI*

**Dr. Leticia B. Puguon**
*Vice President for Programs & Development*
*Governor, Region II*

**Mr. Ariel V. Pabelonia**
*Vice President for Finance*
*Governor, Region IV*

**Mr. Roger P. Tong-an**
*Treasurer*
*Governor, Region XI*

**Dr. Teresita I. Barcelo**
*Governor, NCR Zone 1*

**Dr. Fred B. Ruiz**
*Governor, NCR Zone 2*

**Dr. Edward B. Malzan**
*Governor, NCR Zone 3*

**Ms. Mabel C. San Juan**
*Governor, NCR Zones 4 & 5*

**Dr. Mila Delia M. Llanes**
*Governor, NCR Zone 6*

**Ms. Lolita T. Oracion**
*Governor, CAR*

**Ms. Edelmira S. Bajacan**
*Governor, Region III*

**Dr. Emerlinda E. Alcala**
*Governor, Region V*

**Dr. Roland L.Fermo**
*Governor, Region VII*

**Ms. Elnora C. Quebec**
*Governor, Region VIII*

**Ms. Nerissa H. Alonso**
*Governor, Region IX*

**Ms. Lodar D. Escobillo**
*Governor, Region XII*

**Ms. Jemimah L. Bringas**
*Governor, CARAGA*

**Dr. Mindamora U. Mutin**
*Governor, ARMM*

## HOUSE OF DELEGATES 2012

**Dr. Socorro S. Gasco**
*Chairperson*

**Ms. Nilda B. Pascual**
*Vice-Chairperson*

**Ms. Agnes A. Camacho**
*Secretary*

**Ms. Gloria G. Almariego**
*Treasurer*

## COMELEC COMMISSIONERS 2012

**Ms. Rosemarie N. Garcia**
*Chairperson*

**Ms. Kirsten A. Fermo**
*Commissioner*

**Ms. Maristela P. Abenojar**
*Commissioner*

**Ms. Norenia T. Dao-Ayen**
*Commissioner*

**Dr. Fe B. Espinosa**
*Commissioner*

# SCHEDULE OF SEMINARS

**JANUARY TO MAY 2012**

LIMITED SEATS ONLY!
HURRY! UP TO AVAIL *BIG DISCOUNTS!*

| Date | Seminar | Venue |
|---|---|---|
| January 13, 2012 8am – 12nn | Preventing Blood Incompatibilities: My Perfect Match | PNA Auditorium |
| January 20, 2012 8am – 12nn | Nurses Responsibilities in the Administration of Moderate Sedation/Anesthesia | PNA Auditorium |
| January 31, 2012 8am – 12nn | Ethics in Nursing | PNA Auditorium |
| February 3, 2012 8am – 12nn | Conquering Conflict in the Clinical Setting | PNA Auditorium |
| February 10, 2012 8am – 12nn | Compartment Syndrome: An Orthopedic Emergency that Nurse should know | PNA Auditorium |
| February 17, 2012 8am - 5pm | Independent Nursing Practice: Opportunities & Challenges | PNA Auditorium |
| February 24, 2012 8am – 12nn | What Nurses Should know about Preventing Aspiration | PNA Auditorium |
| March 2, 2012 8am – 12nn | Building and Managing your Career in Nursing | PNA Auditorium |
| March 9, 2012 8am – 12nn | Get your Acts together: Developing your Nursing Leadership Potentials | PNA Auditorium |
| March 16, 2012 8am – 12nn | Overview of Psychiatric Nursing: Dealing W/ Anxious Patients | PNA Auditorium |
| March 23, 2012 8am – 12nn | Coronary Artery Disease (CAD): Nursing Implication to Care | PNA Auditorium |
| April 4, 2012 8am- 12nn | Understanding EKG | PNA Auditorium |
| April 13, 2012 8am – 12nn | Renal Replacement Therapies: Hemodialysis, Peritoneal Dialysis, Hemofiltration & Renal Transplantation | PNA Auditorium |
| April 20, 2012 8am – 12nn | Pediatric Emergency Nursing: Tracheostomy Care | PNA Auditorium |
| April 27, 2012 8am – 12nn | Acute Brain Attack | PNA Auditorium |
| May 4, 2012 8am – 12nn | Nurses Knocking Out Pain Safely with PCA | PNA Auditorium |

• PNA Member P 400.00 • PNA Non Member P500.00

✓ 30% DISCOUNT for the 1st 30 PARTICIPANTS ✓ 15% for the 2nd 15 PARTICIPANTS

*For further inquiries and confirmation, please contact*
**Ms. Sherell Tabafunda at tel. nos. 5210937 & 4004430 loc. 1006.**
**Venue: PNA Auditorium, Phil. Nurses Association, 1663 F.T Benitez St., Malate, Manila.**

# Congratulations to the Accredited PNA Chapters!!!

*Accredited Chapters for year 2009 to 2011*

1. NCR Zone 1
2. NCR Zone 6
3. Benguet
4. Isabela
5. Quirino
6. Nueva Ecija
7. Bataan
8. Albay
9. Negros Occidental
10. Aklan
11. North Leyte
12. Southern Leyte
13. Surigao del Sur
14. Zamboanga- Sibugay
15. Misamis Oriental (Cagayan De Oro
16. Bukidnon
17. Davao City
18. Cotabato City
19. South Cotabato
20. Zamboanga Del Sur

*Accredited Chapters for year 2010 to 2012*

1. NCR Zone 2
2. NCR Zone 3
3. NCR Zone 4
4. NCR Zone 5
5. Baguio City
6. Kalinga
7. Apayao
8. Ifugao
9. La Union
10. Ilocos Sur
11. Ilocos Norte – R1
12. Nueva Viscaya – R2
13. Cagayan North – R2
14. Bulacan – R3
15. Laguna – R4
16. Batangas – R4
17. Catanduanes – R5
18. Iriga-Rinconada – R5
19. Masbate – R5
20. Camarines Sur – Naga City - R5
21. Antique – R6
22. Capiz – R6
23. Negros Oriental – R7
24. Zamboanga City – R9
25. Isabela City – R9
26. Davao del Norte – R11
27. North Cotabato – R12
28. General Santos City – R12
29. Basilan - ARMM

*Accredited Chapters for year 2011 to 2013*

1. Eastern Samar
2. Panagsinan
3. Quirino
4. Nueva Ecija
5. Quezon Province
6. Negros Occidental
7. Davao City
8. Zambales
9. Albay
10. Misamis Oriental
11. Bataan
12. Zone 1
13. Agusan Del Norte
14. Marawi City Lanao Del Sur
15. Tarlac
16. Zamboanga del Sur
17. Cotabato
18. Surigao Del Norte
19. Southern Leyte

*Summary Status of PNA Chapter Accreditation for 2012*

*Out of 93 chapters, there are 42 ACCREDITED CHAPTERS (45.2%)*

| | |
|---|---|
| NCR Zone 1 | = accredited |
| NCR Zone 2 | = accredited |
| NCR Zone 3 | = accredited |
| NCR Zone 4 | = accredited |
| NCR Zone 5 | = accredited |
| NCR Zone 6 | = not accredited |
| CAR | = 4 accredited out of 7 chapters |
| REGION 1 | = 3 accredited out of 4 chapters |
| REGION 2 | = 3 accredited out of 6 chapters |
| REGION 3 | = 4 accredited out of 6 chapters |
| REGION 4 | = 3 accredited out of 11 chapters |
| REGION 5 | = 5 accredited out of 7 chapters |
| REGION 6 | = 3 accredited out of 7 chapters |
| REGION 7 | = 1 accredited out of 4 chapters |
| REGION 8 | = 2 accredited out of 7 chapters |
| REGION 9 | = 2 accredited out of 5 chapters |
| REGION 10 | = 1 accredited out of 5 chapters |
| REGION 11 | = 2 accredited out of 4 chapters |
| REGION 12 | = 2 accredited out of 6 chapters |
| ARMM | = 1 accredited out of 4 chapters |
| CARAGA | = 1 accredited out of 4 chapters |

# Guidelines for Authors

The Philippine Journal of Nursing (PJN) is the official journal of the Philippine Nurses Association, Inc. It is a peer-reviewed journal, published biannually for subscribers and members of the association. It considers original articles written for Filipino nurses at all levels of the health care organization and in various settings. The PJN serves as:

- venue for the publication of scientific and research papers in the areas of Nursing practice and Nursing education,
- source of updates on policies and standards relevant to Nursing practice and Nursing education, and
- medium for collegial interactions among nurses to promote professional growth.

The PJN invites original research and scientific papers, full text or abstract, written by professional nurses on areas of nursing practice and education. If you are interested in submitting a manuscript for possible publication, please review submission requirements below.

## Manuscript Preparation and Submission

Manuscripts are voluntary contributions submitted for exclusive review for publication in the PJN. Manuscripts containing original material are accepted for consideration if either the article or any part of its essential substance, tables, or figures has been or will be published or submitted elsewhere before appearing in PJN.

For additional information about manuscripts and queries about submitting manuscripts, please contact the editor: E-mail: philippinenursesassociation @yahoo.com.ph

The information below indicates the required presentation of manuscripts.

## Format and style

The Publication Manual of the American Psychological Association (APA), Fifth Edition, provides the format for references, headings and all other matters. Check here for additional information about APA style: http://www.vanguard.edu/faculty/ddegelman/detail.aspx?doc_id=796

- Please submit two copies of manuscript, which should not be more than ten pages including abstract, text, references, tables, and figures. The author is responsible for compliance with APA format and for the accuracy of all information, including citations and verification of all references with citations in the text. Spelling may be in either American or British English. Submission must be typed, double spaced on letter-size (8.5" x 11") paper with at least 1" margin on both sides. Include a cover letter listing the author's contact number, address, title, institutional affiliation, position and other relevant credentials. All articles should be addressed to PNA Office at 1663 Benitez St., Manila, Philippines or send through e-mail philippinenursesassociation@yahoo.com.ph
- Manuscripts should be 12 font, double-spaced, with standard margins (about 1 inch). Fancy typefaces, italics, underlining, and bolding should not be used except as prescribed in the APA guidelines.

## Content

The content of a typical manuscript includes:

## Title page

*Title*

Should indicate the focus of the article in as few words as possible. It should not contain a colon or other complex structure. Titles should not exceed about 10 words.

*Author information*

Indicate for each author:

(a) Name and degrees

(b) Title or position, institution, and location; to whom correspondence should be sent, with full address, phone and fax numbers, and E-mail address; provide E-mail address for all co-authors.

*Acknowledgements*

Briefly state name of funders, grant number and name ofmentors/ people with significant contribution

*Abstract*

A structured abstract with headings should be included as part of the manuscript. The abstract denotes: (a) purpose of the article, without detailed background; (b) design, including type of study, sample, setting, dates of data collection if applicable; (c) methods, such as interventions, measures, type of analysis; (d) findings; and (e) conclusions.

For manuscripts focused on review or theoretical analysis a structured abstract still is required, but the organizing construct may be stated instead of a design.

*Key words*

A few key words that are recommended for use in indexing should be listed at the end of the abstract.

*Text*

Successful articles have clear, succinct, and logical organization and flow of content. It contains the following:

- Introduction
- Background
- Methods
- Findings
- Discussion
- Conclusions

The text should indicate the characteristics of the setting in which the study was conducted. Whenever possible, the review of literature and the discussion, interpretation, and comparison of findings should include reference to relevant works published in other countries, contexts, and populations.

## References

Follow the APA Form and Style; list of references should include only those references that are important and cited in the text. References should be the most current available on the topic.

## Tables and figures/photos

Each table and figure should be presented on a separate page and uploaded separately. Placement of each table or figure should be noted in the text. The PJN does not use addenda, appendices, and colors. Photo of the author, as well as photos that highlight article content, are also welcome. Black and white photos are preferred. Drawings and graphics should be clear.

## Time For Review, Decision, and Production

The average time from manuscript submission to the author's receipt of the editor's decision about publication is approximately 3 months. During that time, each manuscript undergoes a rigorous double-blind peer review. The editor's possible decision are (a) accept, with editing to follow immediately; (b) accept, pending satisfactory revisions by the author; (c) not accepted, but author is encouraged to make specified major revisions and return the manuscript to the editor for further consideration; (d) rejected. The editor normally encourages the author(s) to continue the work and to revise and resubmit the manuscript as part of the mentoring culture. The time required for revisions can vary. All manuscripts are edited and copyedited before they are sent to the printer. The corresponding author receives page proofs for approval before publication.

Publication is scheduled at the discretion of the Editor who reserves the right to postpone and cancel publications for reasons of space and other factors. All accepted manuscripts are subject to editing. Authors will receive a complimentary copy of the issue in which their respective articles appear.

## Peer Reviewers

**Carmencita M. Abaquin**, PhD, RN
**Araceli O. Balabagno**, PhD, RN
**Teresita I. Barcelo**, PhD, RN
**Rosana Grace B. Belo**, EdD, RN
**Sheila R. Bonito**, PhD, RN
**Annabelle R. Borromeo**, PhD, RN
**Helen M. Bradley**, PhD, RM, RN
**Irma C. Bustamante**, PhD, RN
**Thelma F. Corcega**, MAN, RN
**Carmelita C. Divinagracia**, PhD, RN
**Letty G. Kuan**, EdD, RN
**Rusty L Francisco**, EdD, RNC, CCRN, CNAA
**Milabel E. Ho**, EdD, RN
**Leticia S. Lantican**, PhD, RN
**Mila Delia M. Llanes**, PhD, RN
**Fely Marilyn E. Lorenzo**, DrPH, RN
**Araceli S. Maglaya**, PhD, RN
**Josefina A. Tuazon**, DrPH, RN
**Deogracia M. Valderrama**, PhD, RN
**Phoebe D. Williams**, PhD, RN

. . . . . .

## *Call for papers*

the PJN January-June 2012 Issue:

"Closing the Gap:
From Evidence to Action"*



**Adopted from theme of the ICN for 2012*

# BOARD OF GOVERNORS 2011

- GOV. TERESITA IRIGO-BARCELO, PhD, RN
  President
  Governor, NCR Zone 1
- GOV. MARIDEL C. DE LA RAMA, RN, MAN
  Governor, NCR Zone 2
- GOV. MA. ASUNCION M. GONZAGA, RN, MAN, PhD
  Governor, NCR Zone 3
- GOV. MABEL C. SAN JUAN, RN, MBAH
  NCR Zones 4 & 5
- GOV. RENIE V. MALVAS, RN, MAN
  Governor, NCR Zone 6
- GOV. RUTH THELMA P. TINGDA, RN, MAN, MM
  PNA Governor, CAR
- GOV. FLORDELIZA R. BOBILES, RN, MAN
  Governor, Region I
- GOV. LETICIA B. PUGUON, RN, PhD
  Governor, Region II
- GOV. NORA GARCIA-CRUZ, RN, MAN
  Governor, Region III
- GOV. ARIEL V. PABELONIA, RN, MSN
  Treasurer
  Governor, Region IV
- GOV. EMERLINDA E. ALCALA, RN, MAN
  Corporate Secretary
  Governor, Region V
- GOV. NOEL C. CADETE, RN, MAN
  Governor, Region VI
- GOV. ROLAND L. FERMO, RN, MAN DPA
  Vice President for Programs & Development
  Governor, Region VII
- GOV. ELNORA O. ARGOTA, RN
  Region VIII
- GOV. FLORENCE A. ALCAZAR, RN, MEd, MAN
  Governor, Region IX
- GOV. NEIL M. MARTIN, MAN, MBE, RN
  Chairperson
  Governor, Region X
- GOV. ROGER P. TONG-AN, RN, MAN
  Governor, Region XI
- GOV. FELINA M. HERNANDEZ, RN
  Governor, Region XII
- GOV. MINDAMORA U. MUTIN, RN, PhD
  Governor, ARMM
- GOV. ZENAIDA C. LAGNADA, RN, CPHN
  Governor, CARAGA


PHILIPPINE NURSES ASSOCIATION
1663 F.T. Benitez Street, Malate, Manila 3004
Telephone Nos: 521-0937, 400-4430 / Telefax 525-1596
Email: *philippinenursesassociation@yahoo.com.ph*

# PNA HYMN

We pledge our lives to aid the sick
To help and serve all those in need
To build a better nation that is healthy and great

We'll bring relief to every place
In towns and upland terraces
In plains and hills and mountains
We shall tend all those in pain

Beneath the sun and stormy weather
We shall travel on
To heed the call that we must be there
With our tender care

We pray the Lord to guide our way
To carry on our work each day
And grant us grace to serve the sick
And love to help the weak

www.pna-ph.org